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PROGRAM NUMBER
Annual Meeting
Medical Society of Virginia
Virginia Beach—October 14, 15, 16

September 1946

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"...Unto the Third and

PROTECTION

PROTECTION against congenital syphilis can often be accomplished by treatment of the expectant mother.

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RICHMOND, VA., SEPTEMBER, 1946

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ANNUAL MEETING (WALTER REED NIGHT) SECTION ON THE HISTORY OF MEDICINE RICHMOND ACADEMY OF MEDICINE MARCH 12, 1946

It is neither necessary nor possible to say what period of history is most significant. The James River, from its headwaters on down through the mountains and the Piedmont, is important to the health and industry of the City of Richmond. So it is with history, and in selecting for review the time dating roughly from the turn of the century, we at least have chosen a period of medical history that has never been surpassed in the rate and weight of its developments. Let any physician of forty years' experience compare his diagnostic and therapeutic procedure of today with that of yesterday.

Neither is it possible to say fairly who has made history. Every announcement of significant discovery is built upon the painstaking labors of many unsung workers gone before. But it cannot be far wrong to suppose that in the medical history of the last half-century, each award of the Nobel prize marks a worthy achievement, and for this reason a list of those awards was attached as a supplement to the program announcement.

In arranging for the speakers at the 1946 meeting of the Richmond Academy's Section on History, I counted myself fortunate in securing the cooperation of three erudite members, who accepted the invitation to present a chapter in modern medical history, each in the field of his special and active interest.

JAMES H. SMITH, *Chairman.*

NOBEL PRIZE WINNERS IN PHYSIOLOGY AND MEDICINE

1901

To EMIL VON BEHRING, for his work on serum therapy and particularly its use against diphtheria.

1902

To RONALD ROSS, for his work on malaria.

1903

To NIELS R. FINSEN, in recognition of his work on the treatment of diseases, and particularly lupus (lupus vulgaris) by means of concentrated radiation.

1904

To IVAN PETROWITCH PAWLOW, for his work on the physiology of digestion.

1905

To ROBERT KOCH, for his work on tuberculosis.

1906

To CAMILLO GOLGI and SANTIAGO RAMON Y CAJAL, for their work on the anatomy of the nervous system.

1907

To CHARLES LOUIS ALPHONSE LAVERAN, for his work on the role of the protozoa in the causation of diseases.

1908

To PAUL EHRLICH and ELIE METCHNIKOFF, for their work on immunity.

1909

To THEODORE KOCHER, for his work on the physiology, pathology and surgery of the thyroid gland.

1910

To ALBRECHT KOSSEL, for his work on the proteins, inclusive of the nuclear substances.

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1911

To ALLVAR GULLSTRAND, for his work on ocular dioptrics.

1912

To ALEXIS CARREL, for his work on the suture of vessels and on the transplantation of vessels and of organs.

1913

To CHARLES RICHET, for his work on anaphylaxis.

1914

To ROBERT BARANY, for his work on the physiology and pathology of the vestibular mechanism.

1915-1918

the prize was not given.

1919

To JULES BORDET, for his discoveries relative to immunity.

1920

To AUGUST KROGH, for his discovery of the capillary motor mechanism, regulating the nutrition of the tissues.

1921

the prize was not given.

1922

Half to ARCHIBALD VIVIAN HILL for his discovery of the release of heat in muscular activity, and half to OTTO MEYERHOF for his discovery concerning the relationship between the consumption of oxygen and the metabolism of lactic acid in the muscles.

1923

To FREDERICK G. BANTING and JOHN JAMES RICHARD MACLEOD for the discovery of insulin.

1924

To WILLEM EINTHOVEN, for his discovery of the electrocardiogram.

1925

the prize was not given.

1926

To JOHANNES FIBIGER, for his discovery of spiropterien carcinome.

1927

To JULIUS WAGNER-JAUREGG, for his discovery of the therapeutic value of inoculation with malaria for general paralysis.

1928

To CHARLES NICOLLE, for his work on typhus fever.

1929

Half to CHRISTIAAN EIJKMAN for his discovery of the antineuritic vitamin and half to F. GOWLAND HOPKINS for the discovery of growth vitamins.

1930

To KARL LANDSTEINER, for his discovery of the various blood groups in the human species.

1931

To OTTO WARBURG, for his discovery of the respiratory ferment.

1932

To CHARLES SHERRINGTON and EDGAR DOUGLAS ADRIAN, for their discoveries on the function of the neuron.

1933

To THOMAS HUNT MORGAN, for his discoveries on the chromosome carriers of heredity.

1934

To GEORGE R. MINOT, WILLIAM P. MURPHY and GEORGE H. WHIPPLE, for their discoveries relative to the treatment of anemias with liver.

1935

To HANS SPEMANN, for the discovery of the effect of the organizer in embryonic development.

1936

To HENRY HALLETT DALE and OTTO LOEWI, for their discoveries relative to the chemical transmission of nerve impulses.

1937

To ALBERT V. SZENT-GYORGYI, for the discoveries relative to the biological oxidations and particularly on vitamin C, and the catalysis of fumaric acid.

1938

To CORNEILLE HEYMANS, for the discovery of the role of sino-carotid and cardio-aortic mechanisms for the regulation of the respiration.

1939

To GERHARD DOMAGK, for the discovery of the antibacterial action of prontosil.

1940-1942

the prize was not given.

1943

Half to HENRIK DAM for his discovery of vitamin K and half to EDWARD A. DOISY for his discovery of the chemical structure of vitamin K.

1944

To JOSEPH ERLANGER and HERBERT SPENCER GASSER for their discoveries on the various functional differentiations of nerve fibers.

A GLIMPSE AT THE DEVELOPMENT OF IMMUNOLOGY AND ALLERGY IN THE LIGHT OF THE CONTRIBUTION OF SIX NOBEL PRIZE WINNERS: VON BEHRING, RICHET, BORDET, METCHNIKOFF, LANDSTEINER, KOCH*

WYNDHAM B. BLANTON, M.D.,
Richmond, Virginia.

I shall attempt to trace briefly the development of immunologic knowledge, with particular reference to the work of six Nobel Prize Winners: Von Behring, Richet, Bordet, Metchnikoff, Landsteiner and Koch, with some attention to the relation of allergy to immunology.

Where shall we begin? With Mithradates protecting himself from poison, as Pliny relates, by taking daily doses of that same poison? With the Chinese practice of inoculation against smallpox 300 years before Christ? With the American Indian physicking his children prophylactically each spring with a decoction of poison ivy leaves? Or shall we begin nearer our own times, with Edward Jenner's successful vaccination of James Phipps in 1796, and the publication of his *Inquiry* in 1798?

Suppose we arbitrarily strike in with Pasteur. It is the year 1881. French sheep have been dying like flies from anthrax. Pasteur's great experiment is at the critical stage. Twenty-five sheep have been inoculated with his anthrax vaccine. Twenty-five controls are in an inclosure close by. To all a lethal dose of anthrax bacilli is given on May 31. Two days and the waiting period is over and the twenty-five unprotected sheep lie dead. The twenty-five vaccinated ones are still hale and hearty. That was the real birthday of the science of immunology.

Time moves on. Henry Sewall at Ann Arbor immunizes pigeons against snake venom. Albert Calmette prepares anti-venin. Pierre Roux discovers the toxin of the diphtheria bacillus and Emil Von Behring tries to duplicate Calmette's success. The meeting of the International Congress on Hygiene and Demography takes place in 1894. The place is Budapest, and Von Behring, a German and first winner of the Nobel Prize, electrifies his audience with the announcement that he has succeeded in making diphtheria antitoxin. He actually has on hand a little vial of antitoxin for those present to take home with them and try for themselves. Victor Vaughan, father of the late Warren Vaughan, is there. And back to America he comes, bringing the first antitoxin to be used here.

*Read before the Richmond Academy of Medicine, Richmond, Va., March 12, 1946, under auspices of the History of Medicine Section.

In all this time others were at work. Paul Ehrlich, chemist, discoverer of salvarsan, specialist in dyes and tissue stains, and the originator of the differential count and vital staining, was formulating his side chain theory and the concept of a foreign protein injuriously linking itself to the protein of the living cell. The link is shed; new receptors are manufactured—many such receptors. The foreign protein came to be spoken of as antigen; the receptors as antibodies, some fixed to the cells, others freely circulating. Thus stated, we have a large part of the mechanism of what is now called acquired resistance. With the events visualized in this way, immunologic study grew apace.

Jules Bordet, a Belgian, an eminent serologist, another Nobel Prize Winner, took a hand. He had discovered bacterial hemolysis and, with Gengou, the whooping cough bacillus and, in 1900, the principle of complement fixation. Bordet viewed immunity from a very different point of view from Ehrlich. To him, a physicist, the process was quite simple. For him no side chains, no chemical formulae—simple physics. Toxin, said Bordet, was neutralized by antitoxin by absorption in a manner similar to that by which a fabric takes up a dye. After saturation is complete it is assumed that toxin is unopposed in its injurious effects. It was as easy as that.

It is time to introduce another of our Nobel Prize Winners, Eli Metchnikoff, a Russian biologist, who was born just a hundred years ago and whose scientific life was spent in the Pasteur Institute. He had, in 1895, demonstrated Pfeiffer's phenomenon *in vitro* (bacteriolysis) and with Roux had successfully inoculated apes with syphilis. He is perhaps more familiar to this audience as the advocate of a once popular theory of old age—intestinal autointoxication, which he believed was to be combated by lactic acid; and for his advice to all those who would attain the dream of Ponce de Leon —that they must drink buttermilk. So doing, he himself attained an age none of his ancestors had reached. I well remember visiting his small untidy laboratory in the Pasteur Institute in 1915, just a little while before his death, to look upon tiers

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and tiers of senescent rats and to be disappointed that the old man was too unwell that day to keep an engagement with a few American students. But Metchnikoff's contribution to immunologic knowledge lay elsewhere. He is the father of the solidist theory of immunity, for it must be remembered that he was the discoverer of phagocytosis, and on his experimental work rest largely our present ideas with reference to opsonins and the function of the white blood cell in the destruction of bacteria in the mechanism of resistance.

We are now in the thick of early immunologic investigation. Everybody was trying either to unearth a new phenomenon or to explain an old one. Flexner, Theobald Smith, Otto, Rosenau and Anderson, each made his contribution. In the course of their research each encountered and recorded a curious reaction—the observation that repeated doses of foreign protein, given parenterally to immunize animals occasionally killed them. No one knew why and no one had the curiosity to find out. But the solution was at hand, and a new department of science was gestating.

At this point we must introduce another recipient of the Nobel Award, Charles Richet, Frenchman and founder of the specialty of allergy. Like other scientists of his day, he was deep in immunclogic research.

He was attempting to determine the toxic dose for dogs of an aqueous glycerine extract of the tentacles of actinaria, when an unforeseen event occurred—the death of dogs following a second injection of an amount of the extract which had proved harmless on the first injection. This led to a careful investigation of the cause. To quote Richet himself:

"The most typical experiment, that in which the results were indisputable, was carried out on a particularly healthy dog named 'Neptune.' He was given at first 0.1 cc. of the glycerine extract without becoming ill; twenty-two days later, as he was in perfect health I gave a second injection of the same amount. In a few seconds, he was extremely ill; breathing became difficult, and he was panting. He could scarcely drag himself along, lay on his side, was seized with diarrhea, vomited blood, sensibility diminished, and he died in twenty-five minutes.

So Neptune, like many another martyr, died that a new idea in science might be born.

In 1901 Richet explained his phenomenon, laying down its two cardinal features, first, that a substance, harmless on the initial injection, may on a subsequent injection, prove fatal; and, second, that a definite interval must elapse between injections. To this phenomenon he gave the now familiar name *anaphylaxis*, thinking that by his first dose he had destroyed something in the animal which protected it against the harmful effect of the poison in the first dose. Mind you, Richet was using highly toxic material. It remained for Arthus, a pupil of his, to show that a non-toxic substance, such as blood serum or milk could produce a similar reaction. It is to be recalled that anaphylaxis was a phenomenon of animals. That a similar mechanism was operative at times in the human body was soon to be set forth by Von Pirquet and Schick. In 1905, in a now famous monograph, *Die Serum Krankheit*, they described for the first time all the many clinical manifestations of serum sickness, and showed that here was a human disease exhibiting both of the features emphasized by Richet as essential in animal anaphylaxis (the harmless first dose and the incubation period). Von Pirquet then proposed a new name for Richet's misnomer. He sought an inclusive word, with ample latitude and so he suggested, to quote him, "the term allergy to designate this general concept of altered capacity to react." It is said that Richet, the discover, was much upset by the general acceptation of another's terminology for his phenomenon.

With the antigen-antibody theory and Von Pirquet's definition, there was now smooth sailing, but only for a short while. Friedberger, Wolff-Eisner, Doerr and Swift, all attempted to sensitize animals to non-proteins. The discovery was soon made that synthetic drugs such as phenolphthalein, arsphenamine, quinine, phenobarbital, and, recently, the sulphonamides were capable of sensitizing the human body. A single aspirin tablet was reported as the cause of sudden death in an aspirin sensitive individual. What was the mechanism? The old protein theory did not suffice, but in 1924 another recipient of the Nobel Prize solved the problem by proving experimentally that by the conjugation of a chemical and a protein (azoprotein) a new antigen was formed capable of stimulating antibody formation, and that thereafter this chemical alone was able to provoke the allergic response in sensitized tissue. This haptin theory we owe to Karl Landsteiner, better known to most of us here tonight, perhaps, as the discoverer of the blood groups which now play such an important role in human transfusions.

The immunologist and the allergist were not

through with their difficulties. Duke introduced in 1924 the concept of physical allergy—a woman so sensitive to light as not to be able to go out of doors without a black veil; a man so sensitive to cold as to hold his life in jeopardy every winter from laryngeal edema and asthma. Still another explanation had to be found. Fortunately at this time Lewis and his co-workers reported the results of their elaborate experiments. He showed that histamine (or, as he cautiously called it, H-substance), a natural constituent of most cells, is released by any one of a number of cellular insults. Such insults might be mechanical, electrical, chemical, thermal, or the antigen-antibody reaction itself. The injection of histamine parenterally into an animal—into the guinea pig, for example—so exactly simulated anaphylactic shock, that not only was histamine regarded as one of the important factors in this reaction, but it thereafter assumed a major role in the explanation of the whole allergic response. Lewis wrote: "The similarity between the histamine reactions and the anaphylactic phenomenon . . . is abundantly clear; it is so clear that a single fundamental cause must inevitably be postulated to explain the two." From this time on the majority of allergies explained the allergic response as a histamine effect, the histamine being liberated in the case of atopic diseases by antigen-antibody reaction; in the case of drug allergy by a haptin antibody reaction; and, in the case of physical allergy, by a direct stimulation of sensitized cells.

If now, for a moment, we should follow the stream of allergy as it has widened in the last forty years since Richet and Von Pirquet, we must take account of *seasonal hay fever,* first recognized as an allergic disease by Wolff-Eisner in 1906; and of *asthma,* first thought of as belonging in the same class by Meltzer in 1910; of *gastro-intestinal anaphylaxis,* described in 1914 in a monograph by Laroche, Richet and St. Girons; of sensitization in *dermatology;* of J. Jadassohn's and Bruno Bloch's early use of the *patch test;* and the recognition of the allergic nature of *contact dermatitis* and *atopic dermatitis,* as well as certain of the eczemas, and finally, the widening application of the allergic theory to diseases of the *nose,* the *eyes,* the *kidneys, cardiovascular disease,* and such disturbances in the domain of *neurology* as *epilepsy, migraine, Ménière's disease,* and some transient *paralyses.*

This brings us to the last of our distinguished Prize Winners—Robert Koch, a German country doctor, who turned to the microscope to give us the life history of the anthrax bacillus, perfected the culture and staining of bacteria, enunciated some famous postulates, discovered the tubercle bacillus, and, in 1890, introduced tuberculin. Here is where he touches immunity and allergy. "The hypersensitivity of the tuberculous animal to tubercle bacilli and products of tubercle bacilli", wrote Zinsser, "is the best known, most typical and most extensively investigated of all the instances of allergy to bacteria and bacterial products. Nevertheless, neither the mechanism of the reaction nor its significance with respect to resistance or susceptibility of an animal to tuberculosis has been definitely determined." Bacterial allergy, of which tuberculosis is such a classic example, is the *bête noir* of the allergist. Only one phase of the subject, however, need detain us now. What is the relation of allergy to immunity? Bret Ratner has recently expressed one viewpoint—stated simply, allergy is the first stage of immunity. During this stage antibody is made by the cells and remains fixed. The second stage begins when sufficient antibodies have been manufactured to overflow into the blood as circulating agents of protection. The situation is not static, for an animal may be first allergic, then allergic and immune and later only allergic. For years most authorities held that allergy is essential to the process of protection and that allergic inflammation is a rapid and effective method of arresting bacterial invasion. In this company were Victor Vaughan, Krause, Opie, Zinsser, Calmette and Hamburger.

The other point of view, that allergy, far from being helpful, is a hazard to the individual, was recently put forth by Arnold Rich in an exhaustive study, *The Pathogenesis of Tuberculosis.* His position seems to be gaining ground. In support of it, he reminds us that there is no correlation between the degree of hypersensitivity and the degree of acquired resistance, that hypersensitive inflammation is not protective *per se* and that specifically acquired resistance may effectively inhibit bacterial spread in the absence of hypersensitive inflammation. He puts it bluntly: "There never has been placed on record one single experiment or clinical observation that demonstrated that hypersensitivity is necessary to protection in any stage of tuberculosis or any other infection, under any conditions whatever," and hypersensitivity and allergy are synonymous.

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HISTORICAL ASPECTS OF INFECTIOUS DISEASES*

KINLOCH NELSON, M.D.,
Richmond, Virginia.

Obviously, it is impossible to review here the complete history of the development of our present knowledge of the infectious diseases, but we shall attempt to lay before you those changes which have occurred in the past fifty years or so, with special attention to the work of the men who have been rewarded by the Nobel prize. In doing so, it is hoped that your attention will be directed to the broad aspects of the problem, that is, to the channels in which medical thinking has flowed from time to time.

Hooper's Medical Dictionary, for the year 1860, gives this definition of contagion: "From the Latin, *contango*, to meet or touch each other. This word properly imports the application of any poisonous matter to the body, through the medium of touch. It is applied to those very subtle particles arising from putrid substances, or from persons laboring under certain diseases, which communicate the diseases to others—as the contagion of putrid fevers, the effluvia of dead animals or vegetable substances, the miasmata of bogs and fens, the virus of small-pox, lues, etc."

It is obvious from this definition that the true nature of those subtle particles we now know as bacteria, protozoa, etc., and their connection with the contagious diseases were not understood. In fact, the question of spontaneous generation was still being argued, as it had been since the time of Anaximander of Miletus, 610 B.C., and Aristotle, 384 B.C. This bugbear was finally laid to rest through the experiments of Tyndall in the 1870's, plus the arguments advanced during the preceding two hundred years by Redi, 1668, Leuwenhoek, 1675, Plencig, 1762, Spallanzani, 1777, Schultze, 1836, Schwann, 1837, Pasteur, 1862, and others.

Despite this lack of concrete knowledge about the infecting agent, the fact that some such agent must exist had been postulated by Henle in 1821. Holmes, in 1843, and Semmelweis, in 1847, had shown that puerperal sepsis was caused by some foreign agent which was carried from an autopsy on a "putrid" case, and could be removed by washing the hands and cleaning the instruments. In the years after 1850, the work of Pasteur on fermentation, plant diseases, and anthrax added great weight to this hypothesis. Also, Davaine, in 1863, demonstrated that anthrax was transmissible, and Villemin and Cohnheim had shown that tuberculosis could be produced by the injection into animals of material from a tuberculous patient; in 1866, Lister, using a German chemical, bichloride of mercury, had shown the value of surgical antisepsis. In 1873, Obermeier saw minute spiral bodies in the blood of sufferers from relapsing fever. Thus, it may be said that the scientific mind was gradually grasping the fact that some living contagion passed from person to person was responsible for the diseases we have under consideration. Handicapped by poor microscopes, inadequate culture methods, and a lack of staining technique, they were unable to get at those very subtle particles, yet they knew they must be there. In this connection, we are reminded of Harvey, who *was not the first* to show that the blood must be passing from the heart through the arteries to the veins and back to the heart. He was confounded as to the route by which it got from artery to vein as he could not demonstrate the capillaries with the apparatus available. These were finally seen by Malpighi in 1660, three years after Harvey's death.

Clinically, the physician was surrounded by fevers, constant, remittent, intermittent, bilious, jail, yellow, and others. Therapeutically, he was a real individualist, each man having his own pet concoction for each particular fever.

Among the students of these problems was Ferdinand Cohn, of Breslau, one of the foremost investigators of bacteria and the first to conclude that they were minute plants. In April, 1876, Professor Cohn received a letter:

"Esteemed Herr Professor:

"Stimulated by your work on bacteria published in contributions to Biology of Plants, I have for some time been at work on investigations of anthrax contagion, as I was able to secure the necessary material. After many vain attempts, I have finally

*Read before the Richmond Academy of Medicine, Richmond, Va., March 12, 1946, under the auspices of the History of Medicine Section.

been successful in discovering the process of development of the bacillus anthracis. After many experiments, I believe myself able to state the result of these researches with sufficient certainty. Before, however, I bring this into the open, I respectfully appeal to you, esteemed Herr Professor, as the foremost authority on bacteria to give me your judgment regarding this discovery. Unfortunately, I am unable to prove this by means of preparations containing the individual stages of development, as the attempt to conserve the bacteria in the respective fluids has failed. I would, therefore, respectfully request you to permit me to show you, within the next few days in the Botanical Institute, the essential experiments. Should you, highly esteemed Herr Professor, be willing to grant my humble request, will you kindly appoint the time when I may come to Breslau."

Professor Cohn was not particularly excited by this letter, as many had previously claimed to have solved the perplexing problems of bacterial growth, development, and relation to disease. However, the appointment was made and on that day, there appeared a small, bearded fellow, shy and of unprepossessing appearance. This doctor began to outline the work he had carried on in his kitchen amid the trials and tribulations of a country practice. Hardly had he begun his demonstration before the Professor realized that epoch-making discoveries had been made, and he sent for his students, Klebs, Loeffler, Auerbach, Traube, Weigert and Cohnheim to hear and see the presentation.

This country doctor was Robert Koch, who laid down and established the dicta suggested first by Henle and known since as Koch's Postulates; who discovered the tubercle bacillus; the poured plate method of culturing bacteria; the cholera bacillus; the typhoid bacillus; who was the father of modern bacteriology and winner of the Nobel prize in 1905.

Dr. Koch's postulates and methods in general were rapidly accepted on the continent, but seem to have caused little excitement among the English, and practically none in this country. Reading over the *Lancet* for the year 1882, one finds a brief note on his description of the tubercle bacillus. Also, we see various letters and articles arguing against the notion of contagium vivum. In this country, Trudeau and a few others grasped the significance of his work and began to study sputum in suspected cases of tuberculosis.

It is interesting that progress is made by adding a little from this brain and a little from that one. Even with Koch's methods and culture media, knowledge of bacteria would have advanced but slowly without the staining methods developed by Weigert between 1871 and 1875.

In this connection, Leeson, a student of Lister's, tells how that great physician became convinced from reading Pasteur's work that the infection so common in compound fractures and so rare in simple ones must be due to some outside agent. This thought came to him late one night, so he hurried to the hospital, removed the dressings from such a case, smeared a slide with the "laudable pus," and put it under the microscope, but saw nothing but the usual debris. If only he had had the stains developed by Weigert ten years later, and the microscopes we all have now, think of how many lives would have been saved, how many arguments would have been avoided, and how many pages of medical journals could have been devoted to other, perhaps, more useless writings.

In the years following Koch's discoveries, scientists everywhere were feverishly engaged in investigating the living causes of infectious diseases. These studies were most admirably rewarded by the discovery of the specific cause of leprosy by Hansen and Neisser in 1879; of gonorrhea by Neisser in 1879; of lobar pneumonia by Pasteur and Sternberg in 1880; of typhoid fever by Eberth and Koch in 1880; of malaria by Laveran in 1880; of tuberculosis by Koch in 1882; of diphtheria by Klebs in 1884; of gas gangrene by Nuttall and Welch in 1892; of plague by Kitasato and Yersin in 1894; of dysentery by Shiga in 1897; and many others.

These studies of bacteria led to the study of other microscopic organisms and their life cycles. In 1879, Manson had followed filaria through the mosquito and contended that this insect carried the disease. Such a notion gained little support, and he was known in the Orient as "Crazy Pat Manson". In 1891, Smith showed that Texas fever was carried by ticks. Ross, following Manson's work on filariasis, was able to show, in 1897, that mosquitoes were necessary for the life cycle of Laveran's plasmodium and were the carriers of malaria. Ross' work was rewarded by the Nobel prize in 1902, and Laveran

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received this prize in 1907. In 1898, Simond showed that plague was carried by fleas; in 1900, Reed, Lazear, and others, following in Finlay's steps, found that yellow fever was carried by mosquitoes; in 1902, Dutton and Sambon showed the connection between African sleeping sickness and the tsetse fly.

As these etiological studies advanced, much work was being done on the effect of these infectious agents on the human body and its response to them. In 1796, Jenner had shown that inoculation with cowpox generated some reaction which protected against smallpox. In 1880 Pasteur, while he was on vacation, accidentally, if such a word can ever be applied to such a man, discovered the principle of attenuation of virus when certain cultures of chicken cholera became incapable of producing the disease, and, yet, when injected, they gave protection against other virulent cultures. Based on this discovery, he developed his vaccine against anthrax, of inestimable value to the sheep industry; and, in 1885, carried this principle into medicine when he produced an attenuated rabies virus which would protect those bitten by mad animals. In 1888, Brieger isolated the toxin of certain bacteria, showing that they generated a poisonous substance which was separate from the bacteria themselves. Using these poisonous substances, or toxins, von Behring, in 1890, found that their injection into animals resulted in the formation of a substance he called an antitoxin, which was present in the blood serum of these animals so that the injection of this serum would protect another animal or person against subsequent infection by the bacteria which produced the toxin. He received the Nobel prize in 1901. In 1896, Widal discovered that infection by bacteria, such as the typhoid bacillus, produced a substance in the serum which would clump these bacteria.

In the early years of the twentieth century, we find, then, that the animate causes of many diseases were known; that their life cycle and mode of transmission had been clarified in many instances; and that their effects an animals and man had been investigated.

During the next two decades, the etiological studies continued with the discovery that rat fleas carried the plague by Verjbitski and Liston in 1903 and 1904; of spirocheta pallida as the cause of syphilis by Schaudinn and Hoffman in 1905; of the bacillus pertussis as the cause of whooping cough by Bordet and Jengou in 1906; that ticks carried Rocky Mountain spotted fever by Ricketts in 1906; and the body louse, typhus, by the same observer in 1910. During this period, however, the greatest activity centered around the application of this new knowledge to the prevention and cure of disease.

The public health field was completely rejuvenated. Prior to the '80s, sanitation authorities had been chiefly concerned with two problems: one, the quarantine and isolation of ill individuals to prevent the spread of contagious disease; and, the other, the disposal of filth, the chief concern being anything which had a bad odor, as such odors were thought to be the source of contagion. The bacteriological discoveries made it clear that the danger lay in the bacterial content and that the most sparkling water, the most delicious milk, even the air itself might, and frequently did, contain the cause of some dread disease. Based on these studies, city filtration and chlorination plants developed so that, in 1911, 20 per cent of the urban population of the U. S. was using filtered water as compared with 6 per cent in 1900. The American Public Health Association standardized the examination of milk in 1910, and carried out studies on the air which were first reported at a meeting here in Richmond in 1909.

From von Behring's original investigations on toxins and antitoxins, and Ehrlich's development of the side-chain theory, vaccines and anti-sera came into use for mass prevention and the treatment of individual sufferers. Thus, the U. S. Army Second Division on maneuvers in Florida in 1898, with 10,759 men had 1,729 cases of typhoid fever and 248 deaths; in 1911, following inoculation with anti-typhoid vaccine, this division with 12,801 men had one case of typhoid. Going hand in hand was the development of diagnostic laboratory work, such as the complement fixation test for syphilis by Wassermann in 1907, and the general use of Widal's bacterial agglutination discovery in the diagnosis of typhoid and other fevers. In like manner, the diagnostic skin tests were developed. More careful clinical study made possible the identification of atypical cases of various diseases, and, more importantly, drew attention to the "carrier", that is, the person who harbors the germs without himself suffering from the disease. In 1884, Loeffler, in his original

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paper on diphtheria, had reported such a case; but the immense significance of the carrier state to disease prevention was not clearly realized until the early 1900s.

Shortly before 1910, Ehrlich became convinced that protozoan diseases would not yield to any vaccine or serum approach and began the search for some chemical which would kill the parasite without killing the host. Through a long series of experiments, he and his student, Hata, discovered that the 606th preparation tried, Salvarsan, was effective against the spirochete of syphilis. Here we see the birth of clinical chemotherapy.

As these advances took place and were consolidated in the public health field, clinical practice, laboratory investigation, and therapy, there occurred the first World War, an unexcelled experimental opportunity to investigate their value. The results need no repetition here.

Since World War I, the public health and prevention idea has progressed by leaps and bounds. For example, let us consider our own state. Although a state board of health was created by the General Assembly in 1872, making Virginia the third state in the union to have such a board, it seems to have functioned but little until 1900, when a salaried secretary was provided and an appropriation not to exceed $5,000 per annum was made. In 1908, the membership of the board was increased from seven to twelve and a commissioner, Dr. Ennion G. Williams, was appointed. The total annual allotment was $40,000. In 1945, the health department was divided into eleven departments or bureaux, employing 454 persons and having a budget of over two and a half million dollars.

In the clinical field, much effort was expended on the development of vaccine and sera, such as anti-pneumococcus serum. Chemo-therapy was expanded with the introduction of various preparations of arsenic and bismuth, useful particularly in syphilis and seemingly having specific effects in certain clinical forms of this disease; of emetine, acetarsone, chiniofon, and vioform in amebic dysentery; of atabrine and plasmochin in malaria; and tartar emetic and fuadin in granuloma inguinale. (Parenthetically, it may be stated that all these drugs left something to be desired.)

To introduce the next great advance, it is necessary to revert to the year 1908, when Gelmo synthesized para amino benzene sulfonamide. In the following year, chemists of the I. G. Farbin Industrie prepared azo dyes with sulfonamide. These preparations were used only as dyes until 1913, when Eisenberg noted that chyrsoidine was bactericidal in vitro. Subsequent to this, Zeide synthesized pyridium which was introduced as a urinary antiseptic. In 1919, Heidelberger and Jacobs developed a number of similar dyes and noted that many of them were highly bactericidal in vitro. During the next few years, the I. G. Farben chemists investigated the therapeutic effects of many preparations of gold, antimony, arsenic and tin with negative results. Early in 1930, Mietzsch, while working toward the synthesis of atabrine which he later accomplished, noted that one sulfonamide preparation was quite effective in the control of experimental streptococcal infections. In 1932, Mietzsch and Klarer patented prontosil, and in 1935, Domagk's controlled animal experiments showed conclusively that this drug was effective against the streptococcus. This work was particularly remarkable in that 100 per cent of the treated animals survived, and gained the Nobel prize in 1939. This report loosed a deluge of chemotherapeutic activity on the continent and in England, but for some reason aroused no particular interest in the U. S., as search of the *Journal of the American Medical Association* in 1935, shows no reference to it. In 1936, however, stimulated by the reports of Colebrook and Kenny in England, American study of these drugs began. Their progress thereafter in this country and abroad is well known to all, but one can scarcely refrain from calling attention to certain specific instances of the effect of the advent of the sulfonamides. Consider lobar pneumonia in Richmond prior to 1940. When confronted by a suspected case, one had little trouble with the diagnosis, made relatively easily by the application of well-tried clinical procedures, the bacteriological methods developed as indicated above, and Professor Roentgen's rays. The family was advised of this dread diagnosis, the patient hospitalized, and nurses engaged (matters requiring no great tact or friends at court in those halcyon days). Oxygen was held in readiness, and one considered the advisability of administering serum, often seemingly more dangerous than the disease, and of doubtful value. The anxiety of the physician and family, faced with a mortality of some 25 per cent as they awaited the hoped for crisis, can now scarcely be appreciated. Turn to the management of this same

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problem with Whitby's sulfapyridine. The preliminaries were the same, but in twenty-four to forty-eight hours there occurred an apparent crisis with gradual and uneventful recovery. The family and physician could go home at night and rest peacefully. The mortality fell from 25 per cent to 4 per cent, statistically scarcely more dangerous than crossing the street. Truly this was a miraculous innovation.

This new slant on therapeutics set off a world-wide search for other bactericidal agents, and in this search, Fleming's experiments in London came to light. Here we recount another of those so-called accidents of science. In 1928 or 1929, Dr. Fleming was studying the possible mutations of the staphylococcus and growing it on various media. In so doing, some of his culture plates, poured by Koch's methods in Petri's dishes, became contaminated with mold; ordinarily such cultures would be discarded, but *these were not,* and Dr. Fleming noticed that the staphylococci in the neighborhood of the mold seemed to be dissolving. He obtained pure cultures of this mold and found that it generated some substance which would diffuse through agar and kill bacteria. Also, this substance, which he called penicillin since it came from the mold penicillium, was bactericidal in a dilution of 1-1000, as compared with carbolic acid which did not inhibit bacterial growth in a dilution of 1-400. Efforts to extract this substance in stable form or produce it in great quantity failed, so that this work lay neglected until 1938, when Florey and Chain, stimulated by the discovery of the sulfonamides, studied the effects of penicillin on infections in animals. From Florey's cultures, investigations in this country added mass production and greater yields. The benefits of this discovery need not be reviewed.

To sum up, then, we have attempted to sketch briefly the recent history of the infectious diseases. We have indicated three major directions of scientific thought: first, toward the discovery of bacteria and their relation to disease from about 1850 to 1910; second, in the application of these discoveries to public and private health from about 1900 to the present; and, third, the development of chemotherapy begun by Erhlich in 1910, and continued by Domagk in 1935, and Florey in 1938. Happily, this last field has not been exhausted.

In reviewing the material necessary for this presentation, one is struck by the advances begun in the nineteenth century. This period saw the first steps toward the intelligent care of the insane, the first attention to conditions of housing and nutrition, and the first child labor laws. During this time, the nursing profession began its rise from the beginnings laid by Miss Nightingale. It must not be forgotten that Professor Roentgen first saw the effects of the x-ray in 1895, and that Trudeau began our present treatment of pulmonary tuberculosis during this period.

It would not be proper in such an address to omit mention of those who died while investigating these diseases: Daniel A. Carrion from verruca peruana; Jesse W. Lazear and Walter Meyers from yellow fever; Alexandre Yersin and Hermann F. Muller from bubonic plague; Tito Carbone from Malta fever; Louis Ferdinand Thuillier from Asiatic cholera; Allen MacFayden from typhoid and Malta fevers; J. Everett Dutton from African relapsing fever; Howard T. Ricketts and James Francis Coneffe from typhus fever; Thomas B. McClintock from Rocky Mountain spotted fever; and Hideyo Noguchi from yellow fever.

In closing, we may permit ourselves certain random observations concerning the infectious diseases. We note the trend from individual research, as exemplified by Koch, to group study as undertaken by the National Research Council, and the introduction of government funds into these problems, a tendency, unwise perhaps, to smother individuality under bureaucratic controls. We wonder what discoveries will follow the broader use of the electron microscope which makes the pneumococcus look larger than a red cell. No doubt these added powers of magnification will show us minute organisms, living on bacteria just as bacteria live on us. The possibilities here are infinite. We do not wonder so much whether we should disclose the secret of atomic energy to some other nation, as whether it might not be well to disclose it to scientists in such a way that some now unknown student may apply it to the solution of problems of disease.

Lastly, in view of our very recent and present troubles, we have been impressed, as perhaps you have, by the fact that among mankind's greatest benefactors, occur the German names Koch, von Behring, and Ehrlich, and the Japanese ones, Kitasato, Shiga and Noguchi.

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DR. WILLIAM S. HALSTED*

HARRY J. WARTHEN, JR., M.D.,
Richmond, Virginia.

If you will read over the list of Nobel prize winners given you this evening you will find that your surgical speaker has been given a difficult assignment if he attempts to stay within the limits outlined by tonight's program. Only two surgeons have received the Nobel prize—Theador Kocher, of Berne, Switzerland, and Alexis Carrell, late of Vichy, France. No English speaking surgeon, not even Joseph Lister, father of antisepsis, has received this honor. Rather than attempt to tell you why either Kocher or Carrell was chosen, I wish instead to describe briefly the career of one American surgeon and in so doing tell you why I think he should have been the recipient of this honor.

William Stewart Halsted was born in New York on September 23, 1852. He attended Andover and Yale before entering the College of Physicians and Surgeons where he received his medical degree in 1877. The following year was spent as house officer in the New York Hospital. He is chiefly remembered during this period for having devised the graphic temperature chart, which has now come into universal use. The next two years were spent in visiting European medical centers. This was a propitious time for a young surgeon to go abroad, for German medicine was then at its best and the field of surgery was being rapidly widened by the application of Lister's teachings in antisepsis. During his stay in Germany he saw much of the pioneer work then being done by Billroth, Wolfler, Von Bergmann, Volkmann, Schede, Esmarch and Mikulicz.

Upon his return to New York in 1880, he was made an associate surgeon at the Roosevelt Hospital and a teacher of anatomy in the College of Physicians and Surgeons. He brought much of the current German concept of antisepsis and early asepsis back with him and he, more than any other American surgeon, modified and then introduced asepsis to this country. About this time he invented the gutta percha protective tissue dressing. This logically led him to devise the present cigarette drain which soon supplanted the dry gauze pack which was formerly universally used. His studies in anatomy at this time lay the ground work for his later operative repair of hernia and his radical amputation for carcinoma of the breast.

His surgery during this era was described as being rapid, brilliant and daring, attributes which he later minimized during his teaching days in

W. H. Welch, W. S. Halsted, William Osler, H. A. Kelly.
(The Sargent Portrait.)

Baltimore. A pathologist at nearby Bellevue Medical College, William H. Welch, saw much of Dr. Halsted during this period and was impressed by the young surgeon's originality and skill. A friendship developed which was destined to influence Dr. Halsted's entire life.

During the winter of 1884-85 Dr. Halsted heard of the discovery by Koller that a little known drug, named cocaine, when placed in the eye would anesthetize the surface of this organ. He and several younger associates experimented upon themselves with this new agent by injecting it subcutaneously and into sensory nerves in order to determine its

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action. They found what is now sometimes called "Halsted's Law", namely, that a cocaine solution, if injected into a sensory nerve, will produce surgical anesthesia throughout the distribution of that nerve. This, of course, is the basis of all regional and spinal anesthesia as used today. Unfortunately, they did not discover until too late in their experiments that cocaine is probably the most powerful of all habit forming drugs. Each member of this small group became addicted to its use and several died as a result. As far as can be determined Dr. Halsted was the only one who was able to overcome this condition and this required the greater part of two years—most of this time being spent under institutional treatment.

During this critical period in his life an institution was taking shape in Baltimore which was to profoundly influence the course of medical teaching in this country. The Johns Hopkins Hospital and Medical School was nearing completion and Dr. Welch was given the task of choosing its staff. He knew of Dr. Halsted's illness and, in fact, had treated him professionally during this time, but his faith in his friend was such that he recommended that he be appointed surgeon-in-chief.

Dr. Halsted's career as professor of surgery is probably familiar to many of you. Several doctors in the audience tonight received their surgical instruction from him and are far better qualified to discuss his life than the speaker. His interests were so diversified and his contributions so many that I will touch on only a few of them.

His early work at Hopkins dealt chiefly with wound healing and the physiology of the thyroid and parathyroids. In New York his operating had been characterized by rapidity and dexterity. In Baltimore he operated slowly, deliberately and anatomically. Every bleeding point was clamped by a small mosquito hemostat and transfixed before it was ligated. His average operating time in a radical amputation of the breast was four hours and it is said that his assistants took care that their operations required no less time lest the professor take them to task for doing an incomplete procedure. His principles for the use of non-absorbable suture material and his emphasis on gentleness in the handling of tissues formed the cornerstone on which our present conception of wound healing rests.

The present operation for goitre is based on the procedure he evolved and described, in which is probably his best known monograph entitled "The Operative Story of Goitre." Technically there has been nothing added to the operation as he did it forty years ago. The medical handling of these cases has been greatly improved, and when it is considered that his cases were done prior to the advent of iodine, thiouracil, oxygen, or any of the other aids to present day thyroid surgery his results are all the more remarkable.

Shortly after coming to Baltimore the new professor of surgery introduced the use of rubber gloves during operations, today the hallmark of every surgeon. Superficially this may appear to be his greatest contribution, but he treated it so casually that the only reference to it that can be found in his writings appeared in 1913, twenty-three years later. Instruments and equipment of various types were devised by Dr. Halsted who had a happy faculty for fulfilling his needs by mechanical aids. Glass spools for silk, the present mosquito hemostats, a suture hammer to facilitate the closure of openings into the common duct, a thyroid retractor which is still in daily use, and a malleable band for the gradual occlusion of great vessels were designed by him, to mention only a few. We, in the Academy, are fortunate to have the first operating table designed and used by him during the era I am describing. By present standards it appears rather primitive but it served its time and generation well and dates the period when he was making his very modern contributions to surgery.

The first decade after his arrival in Baltimore found him writing much about hernia and carcinoma of the breast. The operative repair of hernia prior to 1890 had been a discouraging chapter in surgery. Dr. Halsted, basing his operation on his anatomical dissections made during the New York days, described in 1889 what is now know as the Halsted I repair for inguinal hernia. The procedure, though curative, was more radical than was necessary in the average case and he soon modified it to its present form. The Halsted repair of hernia is the only instance in which his honors were shared with another surgeon, for Bassini of Italy simultaneously described his operation for hernia and all present day procedures are based on the Bassini-Halsted technic. During a recent sojourn in the Middle West I was interested to find that the Halsted I repair which was discarded by

the originator about 1895 is frequently performed today west of the Mississippi.

In 1895 Dr. Halsted published his first paper on his radical operation for cancer of the breast. This described the technic for what has since become the standard operation for this condition and summarized his results. Prior to this time it was often said that "Cancer of the breast is operated upon, but not cured." The usual treatment in the eighties was a simple mastectomy with the removal of a little of the underlying fascia. The pectoral muscles and lymph nodes in the axilla were not disturbed. Dr. Agnew, professor of surgery at the University of Pennsylvania, stated about this time that he "had never been able to cure a cancer of the breast by operation or by other means." While occasional three and even five year cures were reported, the outlook in cancer of the breast was virtually hopeless and this had a correspondingly discouraging effect on efforts to cure cancer in more deeply situated parts. Dr. Halsted, by means of his block dissection of the breast and tributary areas was able to show apparent freedom from recurrence in 42% of all patients operated upon three years or longer. When it is considered that radiation therapy was then unheard of, the results he obtained from surgery alone compare favorably with those of today. The publication of these figures not only stimulated other surgeons to attempt to duplicate his results but also gave fresh hope as to the curability of cancer elsewhere.

The question of intestinal surgery interested Dr. Halsted throughout his professional life. Some of his earliest experimental work at Johns Hopkins was on this subject, and one of his final articles was devoted to a method of aseptic anastomosis which he devised shortly before his death. He was the first to point out the importance of the submucosa whenever intestinal anastomosis was done and the Halsted mattress suture which he introduced is still the most generally used method of reinforcing intestinal suture lines.

He probably saved the hardest problem for the last, for his death in 1922 interrupted his experimental and clinical studies on surgery of blood vessels and treatment of aneurysms. Limitations of time prevent more than a passing mention of his common duct and gallbladder surgery, or his work on osteomyelitis and fractures or transplantation of the parathyroids. His last years at Hopkins in some respects resembled his early days there before the hospital was in operation, for he spent more and more time in the Hunterian Laboratory working out technics which he then turned over to his residents who gave them the test of clinical trial.

It may sound to my listeners that I ascribe all the advances made in surgery during the years 1880 to 1920 to Dr. Halsted. That is not my intention, but the more one reviews his work the harder it is to say that this, or that, is a phase of surgery to which Dr. Halsted did not contribute. He did little in the fields of neurosurgery or urology, but, on the other hand, he suggested to Dr. Cushing that he specialize in neurosurgery and he appointed Dr. Hugh Young as urologist while these men were still on the resident staff, and the pioneer work done by them in their respective specialties stemmed directly from his teachings.

In the final analysis his greatest achievement lay in his choice of his assistants. No teacher of surgery could point to more illustrious disciples than could Dr. Halsted. These included Dr. Finney of Baltimore, Dr. Cushing of Harvard, Dr. Heuer of Cornell, Dr. Reid of Cincinnati, Drs. Holman and Reichert of Leland Stanford, Dr. Watts of the University of Virginia, Dr. McClure of Detroit, Dr. Miller of Pittsburgh, and most recently Dr. Hart of Duke. All of these men with the exception of Dr. McClure became professor of surgery and carried on the Halsted tradition in their respective schools.

Thus far I have spoken of Dr. Halsted as a surgeon, but this account would be incomplete if I did not tell you something of Dr. Halsted as an individual. The originality which characterized his professional life carried over into his private life and took the form of eccentricities which amused or disconcerted his associates as the circumstances determined. Dr. Halsted, unlike his medical counterpart, Dr. Osler, did not have the happy faculty of making friends easily, and his tongue, which veered to the acid side on occasions, discouraged familiarity on the part of his associates. He was admired and respected but he did not inspire affection and his circle of friends was small. He was always faultlessly attired and the high silk hat which he habitually wore became an institution in Baltimore. Early in life he learned that American laundries were unreliable and he had his white shirts washed and ironed in Paris. His shoes also came from Paris and he

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chose the leather from which they were made with such care that he could detect and discard any substitution the bootmaker might attempt.

Romance entered his life shortly after his arrival in Baltimore. The chief operating room nurse was Miss Caroline Hampton of South Carolina. She was a niece of General Wade Hampton and a daughter of Colonel Frank Hampton. Her mother died when she was four and her father was killed in the battle of Brandy Station one year later. The following year "Millwood," her home near Columbia, was burned by Sherman's troops. She was raised by aunts and educated at Edgehill, a school near Charlottesville, which was conducted by Miss Randolph, a great-granddaughter of Thomas Jefferson. In 1886 she entered training at the New York Hospital and upon graduation she came to Hopkins.

On June 4, 1890, they were married at "Millwood" and Dr. Welch was best man. Twenty-three years later, in the only medical article in which Dr. Halsted mentioned either Mrs. Halsted or rubber gloves, the following appeared:

"In the winter of 1889 and 1890—I cannot recall the month—the nurse in charge of my operating room complained that the solution of mercuric chloride produced a dermatitis of her arms and hands. As she was an unusually efficient woman, I gave the matter my consideration, and one day in New York requested the Goodyear Rubber Company to make as an experiment two pairs of thin rubber gloves with gauntlets."

These proved so satisfactory that the resident surgeon, Dr. Bloodgood, also used them, at first for arthrotomies and then for all operations, and Dr. Halsted soon adopted them as well. Had Mrs. Halsted's skin been less sensitive it is probable that this refinement of surgical technic would have been delayed many years.

In some ways the Halsteds were alike. Both were somewhat aloof and limited their friends to a small group. Unquestionably they were both what is sometimes termed strong-minded. In many other respects they differed. Mrs. Halsted represented the aristocracy of South Carolina, and Dr. Halsted's forebearers considered themselves more New England than New York. Their household arrangements were unusual. They purchased a large house on Eutaw Place. Mrs. Halsted occupied the third floor while her husband lived on the second floor. They had their evening meal together. When they entertained, which was infrequent, a great deal of preparation preceded the event. Dr. Halsted personally chose each coffee bean which went into the brew and then ground the coffee himself. The wine likewise received his close supervision. He disliked wrinkles in the tablecloth and ironed the cloth after it had been placed on the table. These dinners became more and more of an ordeal and finally were given up altogether when Mrs. Halsted found they always precipitated an attack of migraine.

Mrs. Halsted liked the rural life but this fondness was not shared by her husband. When the school term was over each spring she would go to their summer home, High Hampton, near Cashiers in the mountains of North Carolina. Her husband, on the other hand, would collect his soiled linen and take it to Paris to be laundered. This accomplished, he would then make his annual visit to various European medical centers. He always included Dr. Kocher's clinic, for a real personal and professional friendship existed between them. Each was influenced by the other and a comparison of their methods shows much in common.

Each fall Dr. Halsted would stop by High Hampton for a few days and he and Mrs. Halsted would then return to Baltimore for another winter. High Hampton incidentally is now a popular mountain resort and is visited by many Richmonders who like its cool nights, remarkable scenery and excellent golf course.

During a visit to England in 1905, Doctors Halsted, Osler, Kelly and Welch sat for the famous painting "The Four Doctors" by John Singer Sargent. This picture, which now hangs in the Welch Library in Baltimore, has caused considerable concern during the past few years due to a gradual fading of Dr. Halsted's portrait. It is now recalled, or at least so goes the story, that the Sargent and the Surgeon did not hit it off too well and that the pigments depicting Dr. Halsted may have been less permanent than those used for the other three subjects. Dr. Osler's comments at the time are of interest in this connection. In a letter to Mrs. Henry M. Thomas he states:

"The picture is an astounding success. The critics are extravagantly enthusiastic. 'No such group since Rembrandt, etc.' I cannot feel that he has done justice to Halsted and Kelly. Welch is wonderfully good. You can see his strength as a

halo. He has caught the ochrous hue of my dour face, but he evidently has no surgical leanings as there is a hidden want in the other two." Be that as it may, Dr. Halsted is slowly fading into the background.

But to return to Dr. Halsted as a surgeon: It cannot be said that his fame has faded during the twenty-four years that have elapsed since his death in 1922. Many honors came to him during the thirty-six years he spent at Hopkins. He was the recipient of numerous honorary degrees and received honorary membership in virtually all of the leading European surgical societies. A few months prior to his death he was awarded a gold medal at a testimonial dinner by the American Dental Association for "original researches and discoveries upon which the technic of local and neuro-regional anesthesia in oral and dental practice now rests." It is significant that this work was done by him forty-five years before the award. The same interval of time elapsed before surgeons generally appreciated the superiority of non-absorbable suture material and just during the past decade have they begun to apply the principles of wound healing laid down by him half a century earlier.

Perhaps this explains the failure of the Nobel Prize Committee to choose Dr. Halsted as a recipient of this award. His contributions to surgery were so far in advance of his times that their full worth were not appreciated during his life. It is reasonable to assume that the Nobel committee fell into this common error—for certainly Dr. Halsted's contributions were second to none during surgery's most formative years.

The National Society for Medical Research.

A clearing house for information on medical studies and discoveries, has been organized under the sponsorship of the Association of American Medical Colleges with the cooperation of 101 national scientific organizations.

Dr. Anton J. Carlson, President of the National Society for Medical Research and Professor Emeritus of Physiology at the University of Chicago, has announced the establishment of the Society's headquarters office at 25 East Washington Street, Chicago 2, Illinois. Ralph A. Rohweder, 1946 President of the Chicago Junior Association of Commerce and former consultant and editor for the National Safety Council, has been appointed Executive Secretary.

The Society has as its purpose the advancement of research in medicine, biology, pharmacy, dentistry, and veterinary medicine.

Dr. Carlson emphasized that an important function of the Society is to analyze and expose the propaganda of small but highly vocal groups which object to the use of animals in the experiments without which medical science would still be in its infancy. Every year doctors and researchers must take time from their vital duties to defeat legislation proposed by these groups which would hamper or stop the work of the medical profession.

New Upjohn Window Display.

Dad, grandmother, and little sister are looking through the window of a hospital nursery in the centerpiece of the 1946-47 Upjohn vitamin window display. The object of their attention is the newly born baby which a nurse is holding up for them to see.

The painting is by Douglass Crockwell and is one which will hold a good deal of human interest for all members of the family. The side pieces of the display are placards picturing different Upjohn vitamin products.

These displays will begin making their appearance in drugstore windows sometime in September.

Winthrop Increases Production.

Increased producion of synthetic amino acids is made possible by new methods of preparation developed in the laboratories of the Winthrop Chemical Company, Inc. Winthrop pioneered in the use of the readily prepared ethyl acetamidocyanoacetate for the synthesis of a wide variety of amino acids, and only two steps are required in production when this intermediate is reacted with an alhyl halide and the resulting product hydolyzed. The new method is useful for the preparation not only of such naturally occurring amino acids as alanine and leucine, but also of many amino acids not known to occur in nature.

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MAKING A CORRECT DIAGNOSIS: ITS IMPORTANCE AND PROBLEMS*

MEADE EDMUNDS, M.D.,
Petersburg, Virginia.

It has been said that good diagnosis is the foundation or basis for doing good medicine, and this dictum is certainly as true in our own fields of ophthalmology and oto-laryngology as in any other branch of medicine.

Will not all of us agree that knowing what is wrong with the patient is the most important thing in determining adequate treatment, in giving an intelligent prognosis, and in keeping the patient, the family, and friends satisfied? On the other hand, not knowing what is wrong makes one wonder if the treatment is adequate, makes an intelligent prognosis impossible, and leads to a state of embarrassment and anxiety on the part of the patient, the family, and relatives.

A case correctly diagnosed gives the physician a certain sense of security because, with this knowledge, he is then able to give the patient the benefit of proper treatment and advice or is in a position to refer the case to some one whom he feels is better prepared to handle the situation.

It is my impression that papers and discussions at most medical meetings, as well as the handling of patients in our offices, tend to place major emphasis on treatment and minor emphasis on diagnosis. The reverse should be true; and if this question of finding out what is wrong with a sick person is perhaps being given too little attention, then we should take stock and ask ourselves the reasons therefor. Perhaps the first and foremost cause is the lack of time that we are willing to give each case, particularly each new patient. In the hustle and bustle of a busy office and a heavy day, are we not inclined to rush just a little too much? Could we not profit by the commands which we have seen so often, namely, Stop—Look—Listen; and I would like to add two others, and perhaps the most important of all, Think and Evaluate! Stop—Look—Listen—Think and Evaluate: if we will take time to do these things, more correct diagnoses will be made. Our diagnostic acumen depends to a great extent on our ability to think and to think in terms of a differential diagnosis. When I was in medical school, I always liked the teachers of medicine who, on quizzes and examinations, would give the class case reports with clinical history, physical, and laboratory findings and would ask, "What is your diagnosis and what would you consider in the differential diagnosis?"

Telescopic vision and telescopic thinking are not consistent with good diagnosis. Our mental, as well as our visual fields, must be broad and not contracted, so that we may be thinking of and seeing the over-all picture and not just an isolated part or that part which concerns our own particular specialty. Is not making a diagnosis somewhat comparable to working a jig-saw puzzle? We must take all the findings, the history, the physical, and the laboratory reports, try to fit them in their proper relationships and then look at the whole picture. The late Dr. Clendening said, "Disease leaves its mark upon the look in a man's eye, the mottling of his skin, the swing of his leg, the bend of his back, and the heave of his chest. It is for you to read these signs."

The history, the physical findings, and the laboratory reports are all important, but I feel that a good history is probably the most important of all; and what do we mean by a good history? Not only let the patient talk, perhaps not as long as some would like to, but at least long enough to get a good idea of the symptoms and to learn the manner in which they are recited. At times I feel that the most important thing in a history may not be what the patient says but the manner in which it is said. It has been my experience, as well as yours, that cases with definite pathology or definite conditions will give a fairly clear cut, concise history and stick to it; on the other hand, patients who fall in the psycho-somatic group give an entirely different type of history, one that is rambling and uncertain with a multiplicity of symptoms varying in intensity and degree and following no logical sequence and having no logical basis. It is with this type of patient that we have to be particularly careful in reaching our conclusions and evaluating the history and physical findings. Does some minor pathology or ab-

*Address of the President delivered before the Virginia Society of Ophthalmology and Oto-Laryngology, at Roanoke, May 4, 1946.

normality account for such a multiplicity of symptoms? Perhaps not. All of us see many cases who have so many more symptoms and complaints than their physical findings could possibly explain; and it may be unwise because we find something that is not exactly in order, to make the patient feel that this is responsible for his complaints. There are many who are out of line when checked with the blood pressure instrument, and shall I venture to say that even the x-ray sometimes discovers things that are often coincidental and not etiologic. We must be realistic and use good judgment and common sense, because there are few of us who have reached the fourth or fifth decade who do not need some replacements, but, unfortunately, these replacements cannot be made.

It is my impression that one of the most frequent diagnostic blunders we make is our failure to recognize the functional basis for so many complaints. I fully realize that extreme care and caution must be exercised not to label a truly organic condition with the label of psycho-neurosis; on the other hand, I also realize that the same care and caution must be exercised not to label a truly psycho-neurotic condition with the label of an organic disease. Both mistakes should be equally embarrassing, and I wonder which mistake is made more often. I believe the latter, and I believe further that it is just as serious an error in diagnosis as the former. With this latter statement, I am sure many of you will disagree, and perhaps you may be justified in doing so; but two years' training in neurology many years ago, plus my observation and handling of patients since that time, leads me to that conclusion. Let us not forget that unsatisfactory and uncomfortable situations in life, disappointments and discontent, often give rise to symptom complexes resembling somewhat organic conditions; and if we do have a tendency to forget this fact, I am sure it will not be long before we will have patients come in who have been the rounds, who have had various operations, not only in our own particular field but in others as well, and who are still complaining and seeking and hoping to find some doctor somewhere who can give them perfect physical health, something they may already have but are not conscious of it. Because these cases cannot or will not recognize the real reason for their situation, they find it more convenient and more satisfying to transfer their symptoms and to look for a more socially acceptable cause.

In conclusion, I want to say that psycho-neurotic conditions have always been with us, but we have not heard too much about them. The men returning from the services have likely gotten a better insight into conditions of this sort than they could have gotten otherwise, and they are going to make us more and more conscious of psycho-somatic medicine. It is a definite field and many of its manifestations are present to a greater or lesser degree in all of us at one time or another. Cases are numerous, but those trained in their handling and understanding are few. Medical schools in the future should pay more attention to instructing and teaching in this branch of medicine than they have done in the past.

502 Medical Arts Building.

Rockwell Kent Medical Drawings Offered by Schering.

A portfolio of reproductions of the unique illustrations recently completed by Rockwell Kent is being offered to interested physicians and pharmacists by Schering Corporation, Bloomfield, New Jersey. The original drawings by the noted painter, Mr. Kent, were commissioned by Schering for use in promotion pieces. Each drawing portrays, in the artist's characteristic manner, the mental symptoms of a patient suffering from a specific endocrine deficiency.

The full color reproductions are eleven by fifteen inches, mounted suitable for framing, and are devoid of any advertising. Portfolios are available free on request.

A REVIEW OF ONE HUNDRED AND TWENTY-NINE CONSECUTIVE CASES OF TUBERCULOSIS TREATED WITH PNEUMOTHORAX OVER A TEN YEAR PERIOD*

THOMAS N. HUNNICUTT, JR., M.D., F.A.C.P.,
Newport News, Virginia.

Six years ago it was my pleasure to present to this Society a five year study and review of clinic patients with pulmonary tuberculosis.† This paper deals with some of those patients as well as all of those who have received pneumothorax treatment since then. One hundred and twenty-nine consecutive patients make up the cases reported on.

Artificial pneumothorax was first successfully performed[1] in 1892, but it was not until 1912 that this procedure became generally accepted.[2] For many years physicians had noted beneficial results in patients with pulmonary tuberculosis when the lung was compressed by spontaneous pneumothorax and/or hydrothorax. In fact, the injection of air into the pleural space was practiced—like so many procedures forgotten and revived in present-day medicine—by Hippocrates, for, according to A. K. Krause,[3] he injected air into empyema cavities.

The rationale of artificial pneumothorax has been stated to be both mechanical and physiological. M. Fishberg has summarized these effects[4] as follows:

A. Mechanical Effects—
   1. It augments existing tendencies to shrinkage.
   2. It approximates walls of cavities.
   3. It prevents the extension of the tuberculous process along the lymphatic and bronchial channels.

B. Physiological Effects—
   1. It produces ischemia of the lung with concomitant passive hyperemia.
   2. It diminishes the circulation of lymph (lymph-stasis).

   These two result in:
   (a) Limitation and demarcation of the affected area of lung tissue.
   (b) Proliferation of connective tissue.

As a result of these changes an exudative process is frequently converted into a productive one.

The procedure of injecting air into the pleural space was denied to many patients because for some time no one considered using this on bilateral cases, and it was thought to be only beneficial in the closing of cavities. Partial or selective collapse solved the problem of bilateral lesions. It was found to help even though the lung was not completely immobilized. Of course, the more perfect the immobilization the better the therapeutic effect.

Another group also denied the full benefits of pneumothorax was made up of patients with adhesions which prevented the collapse of the diseased portion of the lung. At first high positive pressures were tried, but this caused many dangerous complications, such as tearing the visceral pleura with hemorrhage, or the production of bronchiopleural fistula. Also circulatory embarrassment with mediastinal shift manifested itself frequently, and in the author's experience pleural effusions were more prevalent (as is common observation with increased positive pressures). However, in 1914 the operation of cutting most of these adhesions was made possible by the use of the thoracoscope, and another large group of patients was able to receive the benefits of artificial pneumothorax.

The picture will not be complete without mentioning phrenic operations, both temporary and permanent, for, at times, this procedure is not only beneficial but apparently life-saving. Many have seen and reported on the fact that only after this do some patients get a negative sputum (frequently because thick walled cavities do not collapse). It also has a part in controlling the shifting of the heart, mediastinum and trachea, too frequently noted when a long standing pneumothorax is terminated. One case that demonstrates the value of this operation is that of a patient who, due to many thick adhesions, did not get an adequate collapse. After viewing his films, the thoracic surgeon decided these could not be severed. A thorocoplasty was thought to be the procedure of choice, because of the large cavity in the diseased lung. The surgeon did a

*Read before the Seaboard Medical Association of Virginia and North Carolina, at Virginia Beach, December 12, 1945.

†Virginia Medical Monthly **67**:500-507, August, 1940.

temporary phrenic. Four weeks later the patient was transferred to the hospital in preparation for the operation, but when the surgeon returned, films showed that the cavity was much smaller, the sputum negative, and the patient improved greatly. This man was back at work in six months and has remained well for four years. Apparently the shifting of the diaphragm upward had closed the communication between the cavity and the bronchi, thus promoting healing and preventing the disease spreading.

A standard technique has been carried out in starting pneumothorax, as well as in refills. Procaine, 2 per cent, is always used in amounts never over two cc. Epinephrin was at first used in the solution but it was found to be unnecessary as the needle was never in place longer than the effects of the plain anesthetic lasted. Also, many patients complained of unpleasant sensations such as palpation, headache and nervousness directly attributed to the epinephrin. There have been no unusual reactions to this anesthetic either local or systemic. The procaine solution is injected to make a wheal waiting one or two minutes, the 26 G. needle is changed for a larger one (18-22 G.) and the solution is injected as the needle is pushed down to the parietal pleura. At this site slight pain is usually felt and more solution is injected; waiting a few seconds for anesthesia, the parietal pleura is then pierced. Drawing back on the plunger of the syringe and obtaining air proves that one is in the pleural space.

In none of the patients in this series was pleural shock, hemorrhage into the pleural space, or spontaneous collapse of the lung encountered. However, nine years ago, one patient had a needle broken which could not be recovered, it finally located in the posterior sulcus. Refills were continued and the lung re-expanded without any noticeable effect. He has had no complications from this and is well and working, having recently been accepted for life insurance.

The patients are frequently fluoroscoped, usually at each refill, with very short exposures at 4 M.A. or less; for, as has been pointed out recently, indiscriminate fluoroscopy can be dangerous to the patient as well as to the operator. However, this is an essential procedure if one is to adequately and intelligently keep a lung collapsed with the minimum of complications. As is pointed out by Homer L. Sampson, "The x-ray is not the handmaiden, but the mistress of therapeutic pneumothorax."[5]

Several patients in this group were given pneumothorax even though their disease was far advanced and their prognosis very poor. This was done for two reasons: one, it seemed to make them feel better (less toxic), and the other, they seemed to have less sputum with an occasional conversion from positive to negative. These cases are included in the statistics.

PNEUMOTHORAX DISCONTINUED (93 PATIENTS)

Present Condition			
Dead	*Not Improved*	*Improved*	*Well and Working*
(25)	(6)	(9)	(53)
27%	6%	10%	57%

Complications			
Poor Collapse	*Pleural Fluid*	*Empyema*	*Enteritis*
(21)	(36)	(5)	(6)
22%	39%	5%	1%
Pneumolysis	*Phrenic Operations*		*Thoracoplasty*
(6)	(7)		(1)
6%	8%		1%

TABLE 1

The first group to be discussed, Table 1, is made up of ninety-three patients who have had their artificial pneumothorax discontinued. Twenty-five or 27 per cent have died; however, the death rate for the whole series is 19 per cent. The average age of those who have died was thirty-one years. The average duration of the disease before death was three and one-half years. The end was hastened in most of the cases because the disease spread in spite of collapse therapy, but many went to work too soon and neglected their rest. The cry for labor during the war opened many jobs to these people who ordinarily could not obtain work. Two of the patients became worse after ill-advised pregnancies, another became a chronic alcoholic and one had pneumococcic lobar pneumonia in the opposite lung which left him so debilitated that the minimal tuberculosis in this lung lighted up and caused his death in three months.

Sixty-two patients in this group are living and well. Their pneumothorax treatment was carried out for an average of three years, and the average observation period in them has been nearly six years. Seven have had phrenic operations for relief of excessive shifting to the affected side. Four had to have their refills discontinued before advisable, because their lungs would not stay down. Five have had a frank empyema which followed a

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spread of their disease in the presence of pleural fluid. One of these had a rather typical tuberculous pneumonia and subsequently developed a broncho-pleural fistula; two of these are living and well. Six patients in this series have had their adhesions severed in order to give them an adequate collapse. One patient required a thoracoplasty. One patient developed an acute psychosis with delusions of persecution. Her refills were carried on during this time (two months), she is now well and working. One patient died with a coronary occlusion one and one-half years after his lung had re-expanded. Two patients had syphilis, one with an aneurysm; both received specific treatment and are well and working. Thirty-six, or 39 per cent, had pleural fluid at some time during their treatment. Of the sixty-eight patients living, fifty-three, or 78 per cent, are well and working; nine, or 13 per cent, are well, but not working. Six, or 9 per cent, are still resting over eighteen hours per day and are not doing well.

PNEUMOTHORAX CONTINUING (36 PATIENTS)

Present Condition		
Not Improved	*Improved*	*Well and Working*
(5)	(7)	(24)
14%	19%	67%

Complications			
Poor Collapse	*Pleural Fluid*	*Empyema*	*Enteritis*
(5)	(5)	(2)	(0)
14%	14%	6%	
Pneumolysis	*Phrenic Operations*		*Thoracoplasty*
(6)	(0)		(0)
17%			

TABLE 2

Table 2 shows that, of the thirty-six patients still receiving pneumothorax, twenty-four, or 67 per cent, are well and working, seven or 19 per cent are improved, but five, or 14 per cent, are not improved.

The complications in this group are much less, as expected (no deaths), especially in the occurrence of pleural fluid. Some have contended that the presence of fluid does not influence the course of pulmonary tuberculosis treated by artificial pneumothorax, but in this review one is impressed by the seriousness of this complication, for 60 per cent of the patients now dead had fluid at some time during their treatment, whereas, among the living only 30 per cent have had fluid. This trend was noted several years ago and since then an attempt has been made to remove any fluid, noted on fluoroscopy, at each refill.

BILATERAL PNEUMOTHORAX (16 PATIENTS)

Present Condition			
Dead	*Not Improved*	*Improved*	*Well and Working*
(2)	(1)	(3)	(10)
13%	6%	19%	63%

Complications			
Poor Collapse	*Pleural Fluid*	*Empyema*	*Enteritis*
(5)	(7)	(1)	(1)
31%	44%	6%	6%
Pneumolysis	*Phrenic Operations*		*Thoracoplasty*
(4)	(0)		(0)
25%			

TABLE 3

Table 3 is a resume of sixteen patients who have been given bilateral pneumothorax. These same patients are counted in the other tables, but for a comparison this does not matter. The present condition of these patients compares favorably with those in Table 2. Bilateral pneumothorax gives excellent results and there appears to be no more hazard to this procedure than in unilateral cases. Probably many cases which developed a spread should have had bilateral pneumothorax started. The tendency has been to delay, with often fatal results. One patient not included in the series has been receiving 2,000 cc. intraperitoneally for nearly three years. This man refused thoracoplasty and as large adhesions prevented the collapse of his lungs, it was tried bilaterally. Pneumoperitoneum solved his problem. His sputum is negative and he is working every day in a service station.

ALL CONSECUTIVE PNEUMOTHORAX PATIENTS (129)
10-YEAR PERIOD

Present Condition			
Dead	*Not Improved*	*Improved*	*Well and Working*
(25)	(11)	(16)	(77)
19%	9%	12%	60%

Complications			
Poor Collapse	*Pleural Fluid*	*Empyema*	*Enteritis*
(21)	(41)	(7)	(3)
16%	32%	5%	2%
Pneumolysis	*Phrenic Operations*		*Thoracoplasty*
(12)	(7)		(1)
9%	5%		0.8%

TABLE 4

Table 4 gives the complete picture of the whole group of one hundred and twenty-nine consecutive pneumothorax patients over a ten year period. The mortality rate, while too high, still compares favorably with any other method of treating pulmonary tuberculosis. The proof that these people can be and are helped by this relatively simple procedure, that they can expect relief of symptoms in a very

short while and will be able to return to a gainful occupation much sooner than by any other method of treatment, gives them more encouragement to accept artificial pneumothorax. The high percentage of well and working patients in this group bears out this observation. The complications in the group are not serious; in fact, a poor collapse really should not be considered a true complication, but it certainly caused complications. Pleural fluids occurred in 44 per cent of these patients; for the most part they were transitory and responded to aspiration or changes in refills, but it was always considered a serious complication. Empyema occurred in 5 per cent of the patients. It was not always fatal, and in two patients pneumothorax refills were continued. A thoracoplasty was necessary in only one case. Enteritis occurred in three patients (2 per cent) and was always fatal.

In conclusion, artificial pneumothorax, aided by pneumolysis when necessary, and occasionally requiring a phrenic operation on termination, is by far the most conservative as well as the treatment of choice in pulmonary tuberculosis, especially of the ulcerative, caseous, or pneumonic types.

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(Dr. E. L. Trudeau had his lung collapsed by Dr. C. Floyd in 1912, and this gave a great impetus to this comparatively new procedure.)
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303 Medical Arts Building.

Floral Eponym(42)

FOTHERGILLA

JOHN FOTHERGILL, 1712-1780

FOTHERGILL, famous Quaker physician of London, is remembered for his original description of diphtheritic sore throat and facial neuralgia. He was a friend of the American colonies and with Benjamin Franklin, played an important part in the founding of the Pennsylvania Hospital.

Fothergilla is a small genus of North American shrubs of the family Hamamelidaceae, commonly called witch alder. It is related to the witch-hazel. The witch alders are rather ornamental, bloom in April or May and prefer low, moist places.

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THE FORUM

Veterans Eligibility to Medical Treatment.

Physicians seeking hospitalization or out-patient treatment by the Veterans Administration for ex-servicemen can obtain prompt service by furnishing the VA with complete information about the veteran-patient as quickly as possible, Dr. Daniel B. MacCallum, medical director of the VA Richmond Branch, has announced.

In emergencies the family physician often inherits the task of establishing the patient's eligibility for care by, or at the expense of, the VA. Much time can be saved if the doctor obtains the basic facts concerning origin of the veteran's disability and the type of discharge from service before requesting authorization for treatment or hospitalization.

"Normally," Dr. MacCallum stated, "the private physician or hospital verifies the veteran's eligibility for medical care at VA expense before treatment is begun. If this is impracticable because of an emergency situation, the physician should contact the VA Roanoke Regional Office by telephone or telegraph within 48 hours. Delay in such notification may make reimbursement by the VA impossible."

The Regional Office in Roanoke will accept collect telephone calls and telegrams from physicians in emergency cases. The communication must be received within 48 hours after the physician initiates treatment or hospitalization if claims for payment are to be honored by VA. If service-connection of the veteran's disability is questionable, VA is authorized to pay for emergency care pending decision on the veteran's disability claim.

No veteran is eligible for out-patient treatment or hospitalization in other than a VA hospital unless the disability for which such care is desired is service-connected or service-aggravated to a degree deemed pensionable by the VA. Such care for a nonservice-connected disability will be provided, however, if it adversely affects a service-connected condition.

Admissions to VA hospitals are obtainable for veterans of both war and peace-time service. A war veteran is entitled to hospitalization for nonservice-connected disabilities if he has a discharge other than dishonorable, a VA hospital bed is available and not required for a veteran with a service-connected disability, and the veteran swears that he is unable to defray costs of transportation and hospitalization in a civilian hospital.

A peace-time veteran is eligible for hospitalization for a nonservice-connected disability if he received an honorable discharge from his last period of peace-time service, received a Certificate of Disability Discharge for a disability incurred in line of duty or is receiving a pension for service-connected disability, and has no adequate means of support. Peace-time veterans must fulfill the same requirements in obtaining hospitalization for service-connected disabilities except that the "no adequate means of support" condition is omitted.

Women veterans are subject to the same regulations as male veterans except that admission to non-VA hospitals may be authorized for nonservice-connected disabilities. Pregnancies are not considered disabilities for which treatment or hospitalization can be provided by the VA.

Hospital Survey and Construction Act.

With the signing by the President of this Act, an appropriation of 375 million dollars is authorized during the next five years for the construction of hospitals and health centers. Three million dollars is also authorized for State-conducted surveys of need. These must be made preliminary to the granting of Federal funds for construction.

The Act provides latitude for each State to develop its own program of hospital and health center construction, to be administered by State authorities under standards specified by the United States Public Health Service. The Surgeon General will be assisted in establishing standards by a newly created Federal Hospital Council consisting of eight members to be appointed by the Federal Security Administrator.

"This Act sets for the first time a national policy which makes it clear that hospitals in the future must be planned, located and operated in relation to the overall health needs of the people," Thomas Parran, Surgeon General, U. S. Public Health Service said. "This policy, as evolved through the leadership of hospital authorities of the country, is recognition of the integrated role that hospitals and health centers must play in the future. Adequate hospitals, health centers and related physical facilities are the essential workshops, without which it is not possible

to provide even a minimum of modern health and medical services."

Any State may initiate action by submitting a request to the Surgeon General for funds to carry out an inventory of existing hospitals, and to prepare a plan for the construction necessary to provide adequate care for all the people. In making the request, the States must designate a single State agency to carry out the survey and planning and must appoint a properly qualified advisory council to consult with the State agency. The proportionate share for each State of the total Federal appropriation for survey and planning will be determined by the populations of the several States. However, Federal funds must be matched by two to one in defraying the survey expenses.

Allotments for the actual construction of facilities will not be made until the State plan based on the survey findings has been approved. Construction allotments to individual States will vary in amount. Population will be one factor, and in addition, the average per capita income will be used in the allotment formula in such a way that States with a lower per capita income, where there is relatively greater need for medical facilities, will receive proportionately larger allotments per capita.

Applications for funds for individual construction projects must be channeled through the designated State agency. Here again, Federal funds may not exceed one-third of the cost of a project. Before any single project is approved by the Surgeon-General, sufficient evidence must accompany the building request to show that two-thirds of the total cost of construction is available from other-than-Federal sources, and that financial support is adequate for the maintenance and operation of the institution after completion.

Needed—A State Health Council for Voluntary Health Agencies

Unity is essential for a comprehensive health program to attain the best results. The health of a community is, after all, not a group of special interests. It is essentially a single interest with different aspects. To exhalt one of them, to get it out of focus, is unscientific, wasteful and misleading. People are interested in health not only because they want to be free of the aches and pains, but they want to be free of the restrictions and inhibitions that come from physical and emotional deficiencies or handicaps. It is easy, however, to exploit physical shortcomings, sufferings and personal anxieties in the name of "health." This is evident not only from the wide support accorded the voluntary health agencies, but also the tremendous fortunes that have been built up by selling people—in the name of health—everything from bottled tapwater to concentrated vitamins, to say nothing of harmful nostrums or systems. Since the beginning of the century the voluntary health agencies have grown from few to now over twenty thousand.

During World War II, the American Public was asked to contribute to the relief of the various allies in the form of a voluntary fund. In order to eliminate confusion and an overlapping of services the United War Fund was established and local community chests willingly had the public's support of this added agency. This being on a national scope readily demonstrated the most efficient form of voluntary giving. In 1941, the Rockefeller Foundation made a grant to the National Health Council for the purpose of bringing together facts and observations regarding the voluntary health agencies in the United States. As a result of a three-year study, the Gunn-Platt[1] report is a close first-hand study of five hundred and seventy voluntary health agencies. Sixteen national organizations[2] were studied and their segments of regions, city, and county agencies surveyed. This authoritative report makes an analytical study of the voluntary health organizations breaking down the survey into origins, social values, effectiveness, role of state and national organizations, financing, and their future. The professional organizations such as American Public Health Association, American Medical Association, National Safety Council are given a separate study.

The American Red Cross is allotted an entire critical review and not included as one of the fifteen national voluntary organizations. It is stated that

1. "Voluntary Health Agencies"—by S. M. Gunn and Philip S. Platt. Raland Press Co., New York. 1945.

2. List of Organizations: American Cancer Society; American Diabetes Association; American Heart Association; American Public Health Association; American National Red Cross; American Social Hygiene Association; American Society for the Hard of Hearing; Maternity Center Association; National Committee for Mental Hygiene; National Foundation for Infantile Paralysis; National Organization for Public Health Nursing; National Society for Crippled Children; National Society for the Prevention of Blindness; National Tuberculosis Association; Planned Parenthood Federation of America.

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the American Red Cross with its rich contributions in war and peace time is now difficult to recognize in its old form. Needed adjustments are evident in the Red Cross as many official and voluntary health agencies have experienced unhappy working relationships which have been attributed to smugness and self-sufficiency resulting in cooperation seldom in genuine desire or fact. To May 1945, the Red Cross had six hundred and fifty-four million dollars from public support which is unique for any national health agency. The potentialities for its health and leadership improvement are tremendous.

In making this study of the fifteen agencies the purposes of need, support, goals, weaknesses and adjustment to changing times and role in post war years are reviewed. Three fairly distinct types of organizations exist:

1. Specific diseases, as tuberculosis, cancer, poliomyelitis, and diabetes.
2. Disorders of certain special organs such as diseases of the heart, loss of vision, dental defects, locomotor or skeletal disorders (others are those associated with poliomyelitis.)
3. Problems that affect health and welfare of special groups, such as maternal and child hygiene, planned parenthood, etc.

The outstanding trait of the voluntary health agencies has been their freedom, and the lack of cooperation of several of these agencies in a national health council is a fear in relinquishing their identity, mode of financing and their individually attained superiority over other voluntary groups in raising funds. As they offer the people a variety of aids and services and make a variety of appeals, they increasingly confuse the public[3], which often feels itself being pushed in several directions at once. Because of their multiple functions, they have become overlapping, their board members are not well enough informed, and lack of vision and leadership is too frequently observed.

It is also significant that organizations whose purpose is to promote health and to prevent disease should give so little attention to the basic conditions. We find what we should expect—namely, that these people who are the greatest sufferers from poor health live in the worst housing and in the worst environment. They have the lowest level of education —all of these continue endlessly in a vicious circle.

In 1945, the American public contributed fifty-eight million dollars to the fifteen national voluntary health agencies and their local branches. The monies varied from thirty thousand dollars for the American Diabetes Association having six hundred and sixty thousand cases to fifteen million dollars for the National Foundation for Infantile Paralysis having one hundred and seventy-five thousand cases as a grand total and nineteen thousand new cases in 1944. This unevenness of contributions is based on public response—a brace has more appeal than diabetic coma, or heart disease. The ability of a national health agency to obtain public support seems to have little relationship to the agencies relative importance or its effectiveness in advancing the public's health. Agencies with special money raising devices profess a preference to be independent. The average cost of raising a dollar as reported by the Community Chests and Councils is $.059. Of the seven national organizations that ventured an estimate, this varied from 6 cents to 38 cents on a dollar collected.

The most striking fact is the marked unevenness of the voluntary health movement in our country. Excellent societies abound but many are inadequate. The movement has lacked central direction and planning and the time has now come for more coordination of effort. More and more ways must be found to support the voluntary health program without the present competitive and confusing duplication of appeals for funds to which the public is exposed. Several communities have unified their agencies; one of the best known organizations is the Cincinnati Public Health Federation[4], a division of the Community Chest. Montgomery County, Maryland, has had a Health Council in operation for ten years, and it is a division of the Community Chest.

The two agencies with specially effective money raising devices (the National Tuberculosis Association and National Foundation for Infantile Paralysis) should broaden their fields of interest and

3. The reviewer had one patient who was approached by four different health services; he became so confused by excess "sales pressure" brought to bear on his condition that he refused all care.

4. "Twenty-Five Years of Effort and Service"—The Public Health Federation-Division of the Community Chest. Cincinnati, Ohio. December, 1945.

service—the seal sale to support allied promotional-educational activities and the March of Dimes to support services for all the crippled.

The preparation of a national health agency budget should be attempted. Lessons can be learned of the effectiveness of the National War Fund. Out of the experience of budgeting would come a more unified planning and more integrated program of work. It would serve to establish a wider understanding of the essential unity of the human being and attain the highest possible level of physical and emotional health. Governor Tuck has appointed a group composed of a Legislative Commission[5] with State Health Department and Medical Society of Virginia[6] representatives to study such a problem.

Virginia could take the lead in pooling these agencies into a unified group on State level and a State Health Council may well be the objective. This would be an incorporated body including representation from the State Health Department, the Medical Society of Virginia, the Community Chests and Councils, and the principal voluntary health agencies. Such a council could act as a clearing house for the preparation of a state-wide plan of health development. Its functions, among other things, might well be to acquaint the people of the State with the operations of the various existing agencies and at the same time call their attention to areas of service that are still uncovered.

A great achievement would be attained if a State Health Council[7] could succeed in launching a federated fund-raising plan which might be launched throughout the State with the support of the Governor, and would at one time raise sufficient funds to support all of the local voluntary health organizations of the State. This has already proven to be acceptable to the American people through the National War Fund in conjunction with the Community Chests. The Gunn-Platt report stresses throughout the need for unified action in its exhaustive study. The entire text of the report brings the realization of the growing necessity for such an effort. We, of the medical profession have the opportunity to render the people of Virginia an invaluable service in acting as the guiding force to bring this needed unity in the voluntary health services to a reality.

MORGAN B. RAIFORD, M.D.,
Franklin, Virginia

5. First Session of this Commission was held June 21, 1946.
6. VIRGINIA MEDICAL MONTHLY **73**:297, June, 1946.
7. Dr. Louis I. Dublin, Chairman, Executive Committee, for Study of Voluntary Health Agencies. Personal communication. July 3, 1946.

Habit-Forming Properties of Pain Relieving Drug Emphasized.

Emphasizing the fact that Demerol, a substitute drug for morphine, has habit-forming properties, H. J. Anslinger, Commissioner of Narcotics, Washington, D. C., writing in the July 13 issue of *The Journal of the American Medical Association*, says:

"Now comes an article by Paul de Kruif in the June issue of the *Reader's Digest* entitled 'God's Own Medicine—1946' under the headline 'The pain-fighting power of demerol is as miraculous as that of morphine—without the opiate's danger of addiction.' This article adroitly makes no reference to the work of Dr. C. K. Himmelsbach of the United States Public Health Service and Drs. Hans H. Hecht, Paul H. Noth and F. F. Yonkman of Detroit, all of whom warned of the danger of addiction.

"Demerol was placed under federal narcotic control by the Congress because of evidence given before that body of its dangerous properties. Some of the persons referred to in de Kruif's article could have attended the hearings before the Ways and Means Committee and could have testified as to what they thought about the drug, but they elected to remain silent.

"I fear a wave of Demerol addiction if physicians who read this article believe what I consider the reckless and dangerous statements made by de Kruif that the drug is free from addiction properties. This is information somewhat similar to that which appears in the circular distributed by the manufacturer of Demerol to push sales. Had this article been prepared on a strictly scientific basis it would have sounded a strong warning about the danger of addiction. Our files contain numerous cases of addiction involving the use of Demerol."

Demerol, also known as Dolantin, was discovered in Germany and made its appearance several years ago in the Argentine. The author points out that both of these countries immediately placed the drug under strict control.

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PUBLIC HEALTH

L. J. ROPER, M.D.,
State Health Commissioner of Virginia

The report of the Bureau of Communicable Diseases of the State Department of Health for July, 1946, as compared with the same month in 1945, and for the period of January through July, 1946, compared with the same period in 1945, follows:

	July 1946	July 1945	Jan.-July 1946	Jan.-July 1945
Typhoid and Paratyphoid	20	15	58	60
Diarrhea and Dysentery	429	792	1,600	2,375
Measles	473	28	12,701	1,213
Scarlet Fever	70	70	2,022	2,612
Diphtheria	36	11	261	144
Poliomyelitis	14	61	22	87
Meningitis	9	14	157	178
Undulant Fever	5	7	33	18
Rocky Mountain Spotted Fever	18	35	47	53
Tularemia	4	6	38	29

DIPHTHERIA

Diphtheria has become one of the most urgent health problems in post-war Europe. During the past winter, Germany was having as many as 17,000 cases a month; the Netherlands, 5,000 a month; Poland, 4,000 a month; and Czechoslovakia, 3,000. The disease seemed to be particularly virulent, having a high incidence of sequelae and an unusual case fatality rate.

Under the Nazi reign in Germany no large scale immunization program was practiced, and even before World War II diphtheria had begun to increase both in severity and frequency. With the onset of hostilities and the expansion of the Nazi state, immunization both in the homeland and occupied territories was practically forgotten altogether. It is felt that the present situation in Europe is largely due to the development of a virulent strain of C diphtheria in Germany and its exportation into occupied territories, where there were no facilities for immunizing the population.

The question now arises as to whether or not the United States will be affected by the increase in Europe. Without doubt, many men in service in the areas of high incidence have become carriers of virulent diphtheria, although they may never have had obvious clinical manifestations. The probability of the disease being disseminated throughout the United States by returning and returned personnel is great.

Has the United States already been affected? There are certain indications that it has. During the first six months of 1946 there were 1,683 more cases than in 1945, an increase of 24.9 per cent. In Virginia, diphtheria declined steadily through June 1945, making an all time low of 345 cases for the year. This past year, ending June 30, 1946, 669 cases were reported. This is an increase of 94 per cent.

As an index of a change in the virulence of the organism, the ratio of reported deaths to reported cases was computed for the five years. From the table below it will be noted that there has been an increase in this ratio in the past two years. The probability of this increase being due to chance variation is only one in forty.

DIPHTHERIA IN VIRGINIA LAST FIVE YEARS

	Cases	Deaths	Case Fatality Rate
1941-1942	755	44	5.8
1942-1943	648	40	6.2
1943-1944	349	17	4.9
1944-1945	345	29	8.4
1945-1946	669	52	7.8

From the statistics available it appears that both the incidence and virulence of diphtheria here at home are increasing.

Immunization against this disease has been voluntary (to a large extent). Since 1920 the infection in the United States has decreased to such an extent that it has been receiving relatively little consideration. Therefore, certain portions of the populations have not been immunized, and it may be through these susceptibles that the disease will regain its lost prominence.

In conclusion, the following is quoted from a recent editorial appearing in the New England Journal of Medicine: "An immune population is the best assurance against occurrence of a diphtheria epidemic. The low incidence of diphtheria in this country in recent years has created a feeling of security that is totally unwarranted and that, in fact, may be the fuel on which an epidemic will feed unless the dampening effect of widespread immunization serves as a control."

HEMORRHAGE AND OBSTETRIC MORTALITY

COMMITTEE ON MATERNAL HEALTH
MEDICAL SOCIETY OF VIRGINIA

Obstetric mortality rates have been wonderfully reduced during the past fifteen years. This has no doubt been accomplished by the continued study of these problems and the dissemination of information about them. This has been done by the medical profession and not by the legislators who now seek to take over and do the job by using government employees and using the citizens' tax money in lavish manner. It is even proposed in the Pepper Bill to take care of these babies until they are 21 years old, or until they are able to vote.

It must be admitted that the mortality rate is still too high and that preventable deaths still occur too frequently. The problem needs to be further considered. One of the problems is to give hospital care to those who need it. Fortunately, there are now far-seeing legislators or statesmen who recognize this fact and are proposing appropriate measures. However, no appropriation can be efficacious unless the patient receives suitable treatment.

At the present time, hemorrhage furnishes the greatest number of deaths and the greatest number of these is postpartum hemorrhage. In a study made by this Committee of 475 maternal deaths, 92 were due to hemorrhage, 51 of these were classified as postpartum hemorrhage. This study was completed 5 years ago and the proportion of hemorrhage now has been further increased as the toxemia deaths have declined. It was also found that a considerable number of these hemorrhage deaths were classified as preventable. A number of different facts contributed in different cases to this conclusion. Principally, however, the conclusion depended upon whether or not the patient had had the treatment which is generally recognized as being most helpful. It is obvious, therefore, if we are to continue to reduce the mortality, we have to consider these errors and do what we can to prevent them. Several of these patients died after the attending physician had left the home or the delivery room. In looking over them, one is impressed with the fact that treatment was often started too late. Obstetricians are so accustomed to the sight of blood that bleeding is sometimes taken too casually. Portpartum hemorrhage is most likely to occur after long, difficult or instrumental labor. Prenatal study and planned labor may often be the answer to this.

The correct or successful conduct of the third stage of labor is important. There is not an entire unanimity of practice and belief in this respect. Attention is called to the fact, however, that there is much evidence at present to indicate that the placenta in most cases is separated almost immediately after delivery. Where this is true its prompt delivery is highly beneficial. Pressure with the fingers at the junction of the lower third with the upper two-thirds of the uterus with slight tension on the cord will determine this. If it is not separated it is best to wait a reasonable time. Ergotrate given intravenously as the shoulder is being delivered facilitates this considerably or rather it facilitates the delivery of the placenta. After its delivery, pressure on the lower uterine segment carrying the fundus upward as described by Dickinson in 1899 is most helpful. General anesthesia during the third stage of labor conduces to relaxation and hemorrhage. Local anesthesia renders general anesthesia unnecessary in the third stage of labor. The Crede method of expulsion of the placenta so widely used for nearly a hundred years probably in many cases increases the hemorrhage. Waiting a long time for the placenta to be delivered has been considered to be a virtue. If bleeding is at all excessive, the placenta should be removed at once by the method already mentioned but if not, it should be removed manually. Fortunately, if the case has been successfully managed to this point it is very seldom necessary to do this. If any intrauterine manipulation is done this should be preceded by a change of gloves and repreparation of the patient. If no line of separation can be found between the placenta and the wall of the uterus it may be a placenta accreta which is itself a serious complication and usually cause for a hysterectomy. Fortunately, all well-conducted hospitals are now prepared to match blood and give transfusions promptly. A small amount given early is more efficacious than large transfusions later on. Very rarely uterine atony with massive hemorrhage will occur. Here Pitocin is helpful, and tight uterine packing with stimulation of the fundus by manipu-

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lation. Very rarely the condition will require hysterectomy. If the patient has been properly managed to this point this dilemma will almost never occur.

It is obvious that every obstetric case should be managed throughout with the idea in mind of preventing death or injury to mother or child. This result may be approached by keeping in mind at least the principal dangers. A course may be followed which may reasonably be expected to prevent the occurrence of these complications or to give them prompt treatment.

New Books.

Below is a list of some of the newer additions to the Library of the Medical College of Virginia. They are available to our readers under usual library rules:

Altenburg—Genetics.
Anson—Advances in protein chemistry, Vol. 2.
Ash and Spitz—Pathology of tropical disease.
Bancroft and Murray—Surgical treatment of the motor skeletal system. 2 v.
Bancroft and Pilcher—Surgical treatment of the nervous system.
Brooks—Critical studies in legal chemistry of foods.
Boyd—Surgical pathology, 5th ed.
Cantarow—Lead poisoning.
Ciper—Prescription writing and materia medica.
Craig—The Etiology, diagnosis and treatment of amebiasis.
de Navarre—Chemistry and manufacture of cosmetics.
Du Nouy—Studies in biophysics.
Fedder—A girl grows up.
French—Psychiatric social work.
Garrison—Medical bibliography.
Gold—Cornell conference on therapy, vol. 1.
Goldschmidt—A study on spontaneous mutation.
Gould—Trichinosis.
Groves—Marriage.
Harrison—American Foundations for Social Welfare.
Heath—What people are.
Herrick—New Drugs.
Herz—Motor disorders in nervous diseases.
Hesse—Narcotics and drug addiction.
Hollis—Social case work in practice.
Hopkins and Williams—Organic reagents for organic analysis.
Hoskins—The biology of schizophrenia.
Hume—Doctors East, Doctors West.
Justin—Foods.
Kremer—American pharmaceutical documents.
Levinson and McFate—Clinical Laboratory diagnosis, 3rd ed.
Lichtwitz—Nephritis.
Lieber—The Einstein theory of relativity.
McEwen—Textbook of vertebrate embryology.
McCrae—Clinical urology.
McGrath—Nursing in commerce and industry.
Macy—Hidden hunger.
Manson—Dysentery disorders.
Marsland—Principles of modern biology.
Maxwell—Introduction to diseases of the chest.
Mitchell—Textbook of pediatrics. (Moulton, ed.)
A.A.A.S.—Research conference on cancer.
Movitt—Digitalis and other cardiotonic drugs.
Napier—The principles and practice of tropical medicine.
N. Y. Academy of Med. Lecturers to the Laity.—Modern attitudes in psychiatry.
Nicola—Atlas of surgical approaches to bone and joints.
Olson—Prevention, first aid and emergencies.
Patten—Human embryology.
Pregl and Grant—Quantitative organic microanalysis.
Proc. of the workshop on administration of college programs of nursing.
Rafferty—Artificial pneumothorax in pulmonary tuberculosis.
Rahn—Microbes of merit.
Sante—Principles of Roentgen interpretation.
Savory—The Arachnida.
Schwedel—Clinical Roentgenology of the heart.
Skinner—The science of dental materials. 3rd ed.
Smith—Handbook of industrial psychology.
Solomon—Tyroglyphid mites in stored products.
Standardized plant names.
Stern—Medicine in industry.
Stern—Medical services by government; local, state and federal.
Stern—The attendant's guide.
Strecker—Psychiatry in modern warfare.
Sutheim—Introduction to emulsions.
Thewlis—The care of the aged.
Todd—The health care of the family.
Togna—Everybody's way to health and fitness.
Topley and Wilson—Principles of bacteriology and immunity.
Vitamins and hormones, vol. 3.
Weygard—Organic preparations.
Wohl—Dietotherapy; clinical application of modern nutrition.

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PROGRAM

(PRELIMINARY)

98TH ANNUAL MEETING

MEDICAL SOCIETY OF VIRGINIA

CAVALIER HOTEL, VIRGINIA BEACH

October 14, 15 and 16, 1946

BUSINESS SESSION

Monday, October 14

9:00 A.M.

REGISTRATION

9:30 A.M.

COUNCIL—Small Parlor

11:00 A.M.

HOUSE OF DELEGATES—Ballroom

3:00 P.M.

HOUSE OF DELEGATES—Hunt Room

Tuesday, October 15

HOUSE OF DELEGATES—Time and Place to Be Announced

SCIENTIFIC SESSIONS

Monday, October 14

3:00 P.M.

Ballroom

OCCIPUT POSTERIOR AND ITS TREATMENT—Millard B. Savage, M.D., Norfolk

Etiological factors. Discussion of the mechanism of labor with particular reference to anterior and posterior rotation, deflection and arrest. Treatment by a modified Scanzoni maneuver using duplicate forceps.

Discussion—Waverly R. Payne, M.D., Newport News.

COMPLICATED SURGERY OF THE ABDOMEN WITH SPECIAL REFERENCE TO ANESTHESIA, DRAINAGE, PRE- AND POST-OPERATIVE CARE, WITH CASE REPORTS—George A. Wright, M.D., Marion

This series of cases embraces only those with peritonitis of more than a regional scope. Selection of anesthetic is important. These cases necessitate nutrition and in order that there will be no increase in the blood sugar, insulin should be given with intravenous glucose in sufficient amount to prevent even a transient increase. A Penrose drain ordinarily serves every purpose as a substitute for rubber tubing and will minimize the occurrence of post-operative hernia.

Discussion—A. P. Jones, M.D., Roanoke

CARCINOMA OF THE COLON—Frank S. Johns, M.D., Richmond

The author observes that surgery of the colon has advanced rapidly in recent years. For carcinoma, we call attention to the value of immediate aseptic anastomosis following resection of the growth. We wish to emphasize the advantages of the immediate anastomosis over the Mikulicz and other forms of exteriorization of the colon. (*Lantern slides.*)

Discussion—J. M. Emmett, M.D., Clifton Forge

Recess to Visit Exhibits

CURRENT TRENDS IN SURGERY OF THE COLON AND RECTUM FOR CANCER—A. Stephens Graham, M.D., Richmond

There exists a decided trend toward avoidance of either temporary or permanent colostomy in the surgical treatment of cancer of the colon and rectum. This trend is considered critically from the standpoint of immediate and remote mortality (recurrence).

Discussion—R. L. Payne, M.D., Norfolk.

THE NEED IN VIRGINIA FOR TRAINED MEDICAL PHYSICIAN ANESTHETISTS—Harry J. Warthen, M.D., Richmond.

Hospitals in Virginia have not utilized the services of trained medical anesthetists to the same extent as hospitals elsewhere. More widespread use will result in greater safety for operative patients.

Discussion—E. C. Drasch, M.D., Charlottesville

THE TREATMENT OF BURNS—Charles Hamilton Lupton, M.D., Norfolk

Burns are surgical emergencies. Both the local and general treatments must be started promptly. Modified M.C.V. ointment with compression is recommended for the local treatment. Plasma should be given early and in adequate amounts. (*Lantern slides.*)

Discussion—Everett I. Evans, M.D., Richmond
J. G. Price, M.D., Norfolk

Monday, October 14

6:30 P.M.

South Porch of Dining Room

DINNER—Alumni Association, Medical College of Virginia

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Monday, October 14
8:00 P.M.
Ballroom

Call to Order—A. BROWNLEY HODGES, M.D., Chairman, Committee on Arrangements

Invocation

Announcements

Introduction of President

President's Address—JULIAN L. RAWLS, M.D., Norfolk

Memorial Hour—A. M. SHOWALTER, M.D., Christiansburg, Chairman Membership Committee

Address by Guest—JOSEPH S. LAWRENCE, M.D., Director, Council on Medical Service and Public Relations, American Medical Association

Address—WALTER B. MARTIN, M.D., Norfolk, Member of A.M.A. Committee on Medical Service and Public Relations

Tuesday, October 15
9:15 A.M.
Ballroom

UNUSUAL TUMORS OF THE ABDOMEN—Russell Buxton, M.D., Newport News

This paper is devoted to presenting cases where chief physical finding was a tumor in the upper abdomen. The final diagnoses of the cases vary widely and for this reason it is felt that they are of general interest.

Discussion—A. A. Creecy, M.D., Newport News

SURGICAL TREATMENT OF HYPERTENSION AND PERIPHERAL VASCULAR DISEASE — Everett Idris Evans, M.D., Richmond

A report on the influence of sympathectomy on a group of thirty adult patients with hypertension who have been followed from one to three years, post-operatively. All patients have undergone sympathectomy of the Smithwick type; all have had kidney biopsy for correlation with eye-ground findings. (*Lantern slides.*)

Discussion—Nathan Bloom, M.D., Richmond
L. C. Brawner, M.D., Richmond

PRIMARY CARCINOMA OF THE LUNG—Frank Philip Coleman, M.D., Richmond

Eighty-eight consecutive histologically proven carcinomas of the lung were studied relative to symptoms, diagnosis and treatment. The early and late results of lung resections are given and offer considerable encouragement to the management of primary carcinomas of the lung.

Discussion—Arthur B. Gathright, M.D., Richmond

Recess to Visit Exhibits

PENICILLIN IN SYPHILIS—E. E. Barksdale, M.D., Washington, D. C.

The spirocheticidal effect of Penicillins G, F, X and K. The value of Penicillin in the treatment of early syphilis and its expected relapse rate. The use of Penicillin in the treatment of latent and late syphilis. The reaction which may be expected in a Penicillin-treated patient.

Discussion—Thomas Murrell, M.D., Richmond
E. M. Holmes, M.D., Richmond

LUNG ABSCESS IN INFANTS AND CHILDREN. TREATMENT WITH PENICILLIN—George A. Welchons, M.D., and E. L. Kendig, M.D., Richmond

The results obtained in the treatment of lung abscesses in infants and children have been considered by most writers to be of rare occurrence. A review of the literature does not substantiate this assumption. An outline of treatment is presented. Report of three cases. (*Lantern slides.*)

Discussion—I. A. Bigger, M.D., Richmond

PRACTICE OF PSYCHOSOMATIC MEDICINE—John F. Williams, M.D., Richmond

Diagnosis, management and results of treatment of patients with psychosomatic illness based on analysis of selected case reports. (*Lantern slides.*)

Discussion—Howard Masters, M.D., Richmond

Tuesday, October 15
1:15 P.M.
South Porch of Dining Room
Luncheon Meetings of Special Societies

Tuesday, October 15
3:00 P.M.
Ballroom

GASTROSCOPY: AN AID IN THE DIAGNOSIS OF OCCULT HEMATEMESIS—Charles M. Caravati, M.D., and James M. MacMillan, M.D., Richmond

History, physical examination, and x-ray fail to show the origin of the bleeding in many cases of upper digestive tract hemorrhage. Gastroscopy will visualize the site of hemorrhage in many of these cases. Case reports and slides will demonstrate this.

Discussion—D. Coleman Booker, M.D., Richmond

INFECTIOUS HEPATITIS—M. Morris Pinckney, M.D., James O. Burke, Jr., M.D., W. Taliaferro Thompson, M.D., and H. St. George Tucker, M.D., Richmond

Infectious hepatitis, as seen in an overseas general hospital is discussed, the etiology, epidemiology, clinical course, laboratory studies, treatment and criteria for cure being emphasized. (*Lantern slide.*)

Discussion—John Powell Williams, M.D., Richmond

THE COSEASONAL TREATMENT OF HAY FEVER—John L. Guerrant, M.D., and Oscar Swineford, Jr., M.D., University

Methods used at the University of Virginia Allergy Clinic. Analysis of 100 cases with emphasis on results and on factors which might influence the results. (*Lantern slides.*)

Discussion—J. Warrick Thomas, M.D., Richmond.

Recess to Visit Exhibits

PRESENT STATUS OF SHOCK THERAPY—R. Finley Gayle, Jr., M.D., and Claude L. Neale, M.D., Richmond

A report of the results, both good and bad, by the use of insulin, metrazol and electric shock therapy is presented. The evaluation of the results is critically made, and the hazards of the procedure are discussed.

Discussion—Frank H. Redwood, M.D., Norfolk
Joseph E. Barrett, M.D., Williamsburg

THE DIAGNOSIS AND TREATMENT OF HERNIATED NUCLEUS PULPOSUS—James L. Thomson, M.D., Norfolk.

By discussion and lantern slides, particular attention is directed to the history, neurologic findings, and operative procedures for the common location of herniated nucleus pulposus.

Discussion—J. M. Meredith, M.D., Richmond

SEVERE AND FATAL RHEUMATIC FEVER WITH PANCARDITIS IN VIRGINIA—Paul D. Camp, M.D., and Louise Galvin, M.D., Richmond.

Statistics and illustrated cases concerning incidence and severity of fatal and near fatal rheumatic fever and pancarditis in children in Virginia are presented.

Discussion—Samuel A. Anderson, Jr., M.D., Richmond
Walter B. Martin, M.D., Norfolk.

Tuesday, October 15
7:00 P.M.

Dinner

Address by Guest—GEORGE F. LULL, M.D., Secretary and General Manager, American Medical Association

Entertainment

Wednesday, October 16
9:15 A.M.
Ballroom

Symposium on General Practice

PEDIATRICS AS IT RELATES TO THE GENERAL PRACTITIONER—Basil B. Jones, M.D., Richmond

CAN OBSTETRIC CARE BE IMPROVED?—A. L. Carson, M.D., Richmond

ORTHOPEDICS AS IT RELATES TO THE GENERAL PRACTITIONER—George A. Duncan, M.D., Norfolk

NEUROPSYCHIATRY AS IT RELATES TO THE GENERAL PRACTITIONER—J. R. Blalock, M.D., Marion

HYPERTENSIVE VASCULAR DISEASE: ITS EVALUATION AND MANAGEMENT—Julian R. Beckwith, M.D., Clifton Forge

LABORATORY AND DIAGNOSTIC METHODS OF INTEREST TO THE GENERAL PRACTITIONER—Walter B. Martin, M.D., Norfolk

GENERAL DISCUSSION

Installation of W. L. POWELL, M.D., as President.

Adjournment

TECHNICAL EXHIBITS

Technical exhibits will be set up in the South and East Porches and the Loggia. The following is a list of exhibitors, with a brief description of each exhibit:

Booth No. 1

Van Pelt and Brown, Incorporated
Richmond, Virginia

Van Pelt & Brown, Incorporated, manufacturing pharmacists, will occupy exhibition space No. 1. Mr. George J. Hulcher will have charge of the display. Van Pelt and Brown, Prescription Specialties will be featured, especially Gluco Ferrum—the finest type of Iron Medication. We hope to greet all of our old friends and make new ones.

Booth No. 2

Powers and Anderson, Incorporated
Richmond, Virginia

This corporation was established in 1899 with the purchase of a small business located in Richmond a few years previous. known as the Bartlett-Garvens and Company. We think that we are one of the largest and one of the oldest hospital and physicians supply houses in the South. Our business has grown to such an extent that we have started subsidiary companies, one in Norfolk; one in Winston-Salem, North Carolina; and one in Columbia, South Carolina. We are now distributors of the Scanlan-Morris and Company, manufacturers of hospital operating and sterilizer equipment, and the Simmons Company, manufacturers of bedroom equipment.

Booth No. 3

White Laboratories, Incorporated
Newark, New Jersey

White Laboratories, Incorporated, present information regarding White's Sulfathiazole Gum—expressly formulated for topical chemotherapy in oropharyngeal infections; White's Otomide—a more effective means of topical chemotherapy in ear infections—and a NEW specialty, White's Mol-Iron Tablets, a new and definite advance in the treatment of iron deficiency anemias.

White's ethically promoted vitamin specialties are also

featured. You will find a very cordial welcome by White's Medical Service Representatives in charge of the exhibits.

Booth No. 4

William P. Poythress and Company, Incorporated

Richmond, Virginia

A cordial welcome awaits you at the Poythress booth where trial supplies and descriptive literature on Solfoton, Antrocol, T C S, Uro-Phosphate, Panalgesic, Merpectogel, Bensulfoid, and P. M. N. Ointment are yours for the asking.

Booth No. 5

Ciba Pharmaceutical Products, Incorporated

Summit, New Jersey

Ciba invites you to visit its display at Booth No. 5. Among the products displayed will be *Pyribenzamine,* the new antibistaminic compound used in the treatment of allergies; *Privine,* a nasal vasoconstrictor; *Metandren* Linguets, a potent androgen for oral use; *Nupercaine,* a spinal anesthetic, and many others.

Drop in and discuss these products with our representative who will be ready to answer any questions you may have.

Booth No. 6

Doak Company, Incorporated

Cleveland, Ohio

Doak Company exhibits nationally known dermatological preparations. Each preparation is based on the late advances in chemistry and research in dermatology. Latest additions to the Doak Company specialties are: *Salinidol* (Salicylanilid and Carbowax) for ringworm of the scalp; *Prozemoil*—a skin cleanser without the use of water—for eczema; and *Tarpaste,* a carefully standardized distillate of true coal tar 5 per cent in a zinc oxide and starch paste for eczema. Clinical material and literature available upon request.

Booth No. 7

Burroughs Wellcome and Company

New York, New York

Burroughs Wellcome and Company cordially invite physicians to their exhibit of a representative group of fine pharmaceuticals and chemicals. Of particular interest are *Globin Insulin,* a new advance in diabetic control; *Digoxin,* a pure, stable, crystalline glycoside of Digitalis lanata, combining constant, uniform potency with rapidity of action; *"Dexin"* High Dextrin Carbohydrate, the milk modifier in which the non-fermentable portion predominates, and *"Lubafax"* Brand Surgical Lubricant, one of our newest preparations.

Booth No. 8

Liebel-Flarsheim Company

Cincinnati, Ohio

It will be a privilege for The Liebel-Flarsheim Company to exhibit their new SW-227 Frequency Controlled Short Wave Diathermy, Ultra-Violet Orificial Generators, and *Bovie* Electrosurgical Units at the 1946 Annual Meeting of the Medical Society of Virginia.

Mr. R. D. Armiger, district manager, and Mr. F. M. O'Connor, our Virginia representative, cordially invite you to visit booth 8 for examination and demonstration of the above equipment.

Booth No. 9

Philip Morris and Company

New York, New York

Philip Morris and Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

Booth No. 10

Peoples Drug Stores

Washington, D. C.

Peoples Service Drug Stores Prescription exhibit is based on the careful handling of the value of prescriptions filled in each Peoples Service Drug Store Prescription Department, together with an interesting showing of drugs and specialties. A representative of the Company will be present and will gladly give any information desired by physicians.

Booth No. 11

Coca-Cola Bottling Works, Incorporated

Norfolk, Virginia

Welcome to the Medical Convention at Virginia Beach! We shall be looking for you at our booth with a frosty bottle of Coca-Cola. Stop by often and enjoy a Coke with us.

Booth No. 12

A. S. Aloe Company

St. Louis, Missouri

The Virginia representatives of the A. S. Aloe Company will be happy to meet their friends at Booth No. 12.

On display will be a cross section of medical and laboratory equipment and supplies. A large selection of army surplus items will be featured. These items are double-barrel bargains: first, because all of the items are new, first quality items selling at a fraction of their usual cost; and second, because they are immediately deliverable.

You will be well repaid for your visit to Booth No. 12.

Booth No. 13

U. S. Vitamin Corporation

New York, New York

Full color illustrated brochure "Diagnosing Vitamin Deficiencies" together with professional samples and literature on Vi-Syneral, Poly-B, Vi-Litron, Hypervitam, Lipo-Heplex, Dalsol, Desiver and others.

Booth No. 14

E. R. Squibb and Sons

New York, New York

An exhibit showing the blood levels produced by Penicillin when administered in either Oil or Wax or in aqueous solution. Dosages for a variety of diseases are also shown.

Booth No. 15

Lanteen Medical Laboratories, Incorporated

Chicago, Illinois

This manufacturer will exhibit the improved *Lanteen Flat Spring Diaphragm, Hexestrol* (Lanteen), *Hexypheen* (Hexestrol with Phenobarbital), as well as *Vi-Teens* Products.

Included in their *Vi-Teens* display are *Vi-Teens Homogenized Vitamins,* a multi-vitamin palatable emulsion formulated for the dietary vitamin supplement for infants and children.

Booth No. 16

Holland-Rantos Company, Incorporated

New York, New York

You are cordially invited to visit the Holland-Rantos booth where on display will be the nationally known and universally used Koromex contraceptive specialties. Besides the new Koromex Set Complete, which is a package combining the necessary items for complete contraceptive technique, will be the new Nylmerate Jelly introduced only a short time ago and received enthusiastically for the treatment of trichomoniasis and vaginal discharges of a non-specific origin. Representatives of the company will be on hand to answer all questions. Samples of Nylmerate Jelly and Koramex Jelly will be available as will copies of the Dickinson-Freret Charts.

Booth No. 17

Valentine Meat-Juice Company

Richmond, Virginia

Valentine's, now celebrating its seventy-fifth anniversary in business, envisions increasing future service to the medical profession. Founded in 1871, its Meat and Liver Extracts are known and used all over the world.

Improvements in quality and variety of its products and processes are attested by increased prescribing of Valentine's Liver Products; wide acceptance of its Liver and Meat Extracts and Concentrates in bulk by the pharmaceutical trade.

Our ever increasing research facilities portend an assured progress in the development of other worthwhile products.

Booth No. 18

C. B. Fleet Company, Incorporated

Lynchburg, Virginia

Phospho-Soda (Fleet) has been an ethical product for over half a century. It is a highly concentrated, purified, aqueous solution of the two U.S.P. phosphates in stable form. It is rapid but mild in action, without irritation of the gastric or intestinal mucosa. It is indicated in hepatic and gall-bladder dysfunctions, and for a thorough eliminating and cleansing action on the upper and lower gut.

Booth No. 19

R. J. Strasenburgh Company

Rochester, New York

The R. J. Strasenburgh Company, founded in 1886, has been engaged in the development, manufacture, and distribution of ethical pharmaceutical specialties for the past sixty years. During these sixty years, sound research has made the R. J. Strasenburgh Company known to discriminating physicians as a source of dependable pharmaceuticals.

"Pioneered by Strasenburgh Research" has come to mean to the medical profession a quality product of proven value.

Booth No. 20

Schering Corporation

Bloomfield, New Jersey

The Schering exhibit will feature the latest developments in endocrine therapy, radiographic aids and other pharmaceutical advances.

Of particular interest is the presentation of Combisul-TD. Combisul-TD is a sulfonamide combination based upon the now proved therapy which offers the therapeutic benefits of sulfathiazole and sulfadiazine with a material decrease in the danger of renal toxicity and crystalluria.

Schering professional service representatives will be present to answer inquiries and to provide valuable, informative literature.

Booth No. 21

The Doho Chemical Corporation

New York, New York

The makers of *Auralgan* are introducing at this meeting their new sulfa drug preparation *O-Tos-Mo-San,* indicated in the treatment and control of chronic suppurative ears. Our representatives will be happy to explain, in detail, the workings of these medications.

Also to distribute our latest series of three Anatomico-Pathologic Charts of the Ear, in color, suitable for framing.

Booth No. 22

Parke, Davis and Company

Detroit, Michigan

Representatives of Parke, Davis and Company, well informed concerning progress in pharmaceutical research, and desirous of presenting new advancements to you, will be in attendance at our Technical Exhibit to discuss the nature and employment of new and present products. Displayed will be such outstanding products as *Theelin, Mapharsen,* and *Adrenalin Preparations.* The latest type of Biologicals will be on display. Likewise, Penicillin and other therapeutic agents of antibiotic, biological, and chemotherapeutic interest will be shown. We sincerely invite your visit to this exhibit.

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Booth No. 23

A. H. Robins Company

Richmond, Virginia

The firm of A. H. Robins Company is one of the oldest pharmaceutical houses in the state of Virginia. It was founded in the year 1878 and has served the medical profession continuously since that time. In recent years the medical service staff has been increased so that practically every section of the United States is now covered by Robins' men.

E. C. Robins, who is president of the Company, is the grandson of the founder, A. H. Robins. Mr. Robins is a graduate of the Medical College of Virginia School of Pharmacy.

Booth No. 24

Reed and Carnrick

Jersey City, New Jersey

Since 1860 the high ethical and scientific ideals of the Reed and Carnrick Laboratories have continued to merit the confidence and support of the American medical profession.

Scientific research and rigid technical supervision assure the potency, clinical efficacy and economy of all medicinal agents bearing the name.

Booth No. 26

Hoffman La Roche, Incorporated

Nutley, New Jersey

Pharmaceutical prescription specialties of rare quality produced at Roche Park, where vitamins are made by the ton, will be exhibited. The medical profession's interest in *Per-Os-Cillin,* the new stable oral penicillin; the versatile parasympathetic stimulant prostigmin; and other scientific accomplishments will be satisfied by Hoffmann-LaRoche representatives who will be in attendance to discuss clinical problems.

Booth No. 27

Winthrop Chemical Company, Incorporated

New York, New York

Winthrop Chemical Company, Incorporated, extends a cordial invitation to visit Booth No. 27 where representatives will gladly discuss the latest therapeutic contribution made by this firm.

Booth No. 28

Sharp and Dohme, Incorporated

Philadelphia, Pennsylvania

Sharp and Dohme will have on display at their exhibit space the following products: *Sulfathalidine, Sulfasuxidine, Lyovac* Normal Human Plasma, *Prothricin, Tyroderm* Tyrothricin Cream.

A cordial welcome awaits all visitors.

Booth No. 29

The Borden Company

New York, New York

Spend a few minutes with Borden at Booth No. 29—refresh your memory on our Prescription Products. Meet Biolac, a concentrated liquid modified milk for infant feeding; New Improved Dryco with its high protein-low fat content for formula flexibility; Mull-Soy, liquid, emulsified soy food for your milk allergic patients; powdered whole milk Klim, a dependable source of whole milk; the improved milk sugar, Beta Lactose for carbohydrate supplementation; and the powdered Merrell-Soule Protein and Lactic Acid milks for special infant feeding cases.

Booth No. 30

Camel Cigarettes

New York, New York

Camel Cigarettes will present a dramatic full color review of their recent medical research on smoking, as well as the details of the nationwide survey showing that "More Doctors Smoke Camels Than Any Other Cigarette". Another panel will illustrate the absorption of nicotine in the respiratory tract. Representatives will be present.

Booth No. 31

General Electric X-Ray Corporation

Chicago, Illinois

The coming meeting marks the twentieth consecutive year that the General Electric X-Ray Corporation has had the privilege of an exhibit at the annual meeting of the Medical Society of Virginia. New models of physical therapy equipment and x-ray accessories will be on display.

Booth No. 32

Mead Johnson and Company

Evansville, Indiana

"Servamus Fidem" means We are Keeping the Faith. Almost every physician thinks of Mead Johnson & Company as the maker of Dextri-Maltose, Pablum, Oleum Percomorphum, and other infant diet materials—including the new precooked oatmeal cereal, Pabena. But not all physicians are aware of the many helpful services this progressive Company offers physicians. A visit to Booth No. 32 will be time well spent.

Booth No. 33

Tablerock Laboratories

Greenville, South Carolina

We invite the members of the Medical Society of Virginia to visit our exhibit during the meeting. Our representative will be glad to explain the line of prescription specialties we have to offer for your service.

Booth No. 34

Bilhuber-Knoll Corporation

Orange, New Jersey

Among the fine medicinal chemicals displayed by Bilhuber-Knoll Corporation are Metrazol, circulatory and respiratory restorative and antianoxiant; Octin, antispasmodic in ureteral and like spasms; Dilaudid, analgesic and cough sedative; Theocalcin, myocardial stimu-

lant and diuretic; Bromural, sedative and mild hypnotic; Euresol pro capillis, and other dependable products.

These prescription chemicals are often components of everyday prescriptions, prescribed alone or in combination with other drugs as the individual patient may require.

Booth No. 35

Ortho Pharmaceutical Corporation

Linden, New Jersey

The Ortho Pharmaceutical Corporation will exhibit their well-known line of gynecic pharmaceuticals. Featured will be their new product for treatment of bacterial vaginitis—Triple Sulfa Vaginal Cream.

You are cordially invited to visit booth No. 35. Samples and literature on all products will be available upon request.

Booth No. 36

Eli Lilly and Company

Indianapolis, Indiana

The Lilly exhibit will feature an interesting demonstration in miniature on penicillin culture. Many Lilly products will be on display, and attending Lilly medical service representatives will be present to assist visiting physicians in every possible way.

Booth No. 37

Meridian Electronic Equipment Company

Richmond, Virginia

Intercommunication, sound and paging systems for office and hospital use will be arranged so as to vividly describe the many possibilities of efficiency and convenience inherent in this type of equipment. The physician will be shown how his personal time and thousands of steps of his assistants can be saved; how doctors and nurses may be paged; how individual patients can have radio programs; and other devices whereby the profession can render even more efficient service.

Booth No. 38

J. B. Lippincott Company

Philadelphia, Pennsylvania

Be sure to see the current issue of *American Practitioner*—a new medical journal designed to shorten the lag between experiment and practice.

Titles of new books and new editions now ready or in active preparation include: Operative Gynecology; History of Medicine; Diabetic Care in Pictures; Diagnostic Examination of the Eye; Surgical Treatment of the Motor-Skeletal System; Surgical Treatment of the Nervous System; Treatment of Bronchial Asthma, and Pitkin's Conduction Anesthesia.

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WOMAN'S AUXILIARY
to the
MEDICAL SOCIETY OF VIRGINIA

President—MRS. PEYTON MONCURE CHICHESTER, Richmond
President-Elect—MRS. J. E. HAMNER, Petersburg
Recording Secretary—MRS. NATHAN SCHUMAN, Alexandria
Corresponding Secretary—MRS. L. C. BRAWNER, Richmond
Treasurer—MRS. REUBEN F. SIMMS, Richmond
Parliamentarian—MRS. E. LATANE FLANAGAN, Richmond
Historian—MRS. H. A. LATANE, Alexandria

PROGRAM (Tentative)

Twenty-fourth Annual Meeting

Virginia Beach **October 15, 1946**

Headquarters: Cavalier Hotel

A cordial invitation to attend the meetings and entertainments is extended to every woman attending the Convention.

Registration begins on the afternoon preceding the opening meeting, and each woman is requested to register promptly upon arrival, either as delegate or visitor. (Registration fee—25 cents).

Registration Booth open Monday, October 14, from 5:00 P. M. to 6:00 P. M. and from 7:30 P. M. to 8:30 P. M.

CHAIRMAN OF LOCAL ARRANGEMENTS—Mrs. H. F. Dormire.

Tuesday, October 15

8:00 A.M.—Registration Booth open. Cavalier Hotel.

9:00 A.M.—Pre-Convention Board Meeting.

All local Presidents, Presidents-Elect (or Vice-President where there is no President-Elect), State Officers and Chairmen are expected to attend this meeting.

GENERAL ANNUAL MEETING

10:00 A.M.—Cavalier Hotel.

Open to all women attending the Convention.

Mrs. Peyton Moncure Chichester, President, presiding.

Invocation.

Address of Welcome.

Response.

Report of Committee on Arrangements—Mrs. H. F. Dormire, Chairman.

Report of Committee on Registration and Credentials.

In Memoriam.

Minutes of the Twenty-third Annual Convention.

Minutes of the Post-Convention Board Meeting.

Minutes of the Mid-Winter Board Meeting.

Roll Call of Local Auxiliaries—Mrs. Nathan Schuman, Recording Secretary.

President's Message—Mrs. Peyton Moncure Chichester.

President's Announcements.

Reports of officers and chairmen of standing committees.

Reports of local Presidents.

Report of delegate to the Woman's Auxiliary to the Southern Medical Association.

Unfinished Business.

New Business.

Recommendations from the Board.

Presentation of Membership Trophy.

Acceptance of Trophy.

REPORTS—

Committee on Resolutions.

Nominating Committee—Mrs. Paul Pearson, Chairman.

Election of Officers.

Installation of Officers, Mrs. E. Latane Flanagan, Parliamentarian.

Presentation of Gavel.

Adjournment.

LUNCHEON MEETING

1:30 P.M.—"Auxiliary Day" Luncheon (subscription) honoring especially invited guests of the Medical Society and Auxiliary with their husbands and wives; honorary Auxiliary members (Miss Agnes Edwards and Mrs. William Lett Harris); past Presidents of the Auxiliary; the retiring and incoming Presidents of the Medical Society and their wives; the Presidents of the Auxiliaries to the American Medical Association and the Southern Medical Association and the members of the Advisory Council and their wives.

Greetings—Dr. Julian Rawls, President Medical Society of Virginia.

Inaugural Address of President—Mrs. J. E. Hamner.

Guest Speakers

3:00 P.M.—Post Convention Board Meeting.

7:00 P.M.—Banquet of the Medical Society of Virginia and Auxiliary to the Medical Society of Virginia.

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EDITORIAL

The Annual Meeting

THE first post-war meeting of the Medical Society of Virginia, October 14, 15, and 16th, promises to break all attendance records. The medical profession is *meeting-hungry*. Doctors who have been separated by the war will have an opportunity to get together under ideal surroundings. Those who know, say the Beach is at its best in October. It is not too late to go swimming, and is cool enough just to sit and enjoy living. The golfers and fishermen will have splendid opportunities to indulge in their favorite sport. And last, but not least, a splendid scientific program has been arranged, and there will be all the exhibits that space will permit. The Special Societies will meet in groups for luncheon on Tuesday, the 15th.

The Cavalier has been "sold out" for weeks, but good accommodations may be had at several other hotels.

Dr. Riggin Resigns as Health Commissioner

DR. I. C. RIGGIN resigned as State Health Commissioner August 7th, the position which he had filled since 1934. At that time he succeeded Dr. Warren F. Draper who had been loaned to Virginia by the United States Public Health Service.

Among the first of the activities undertaken by Dr. Riggin was to discuss with and to acquaint the medical profession of Virginia with the programs which should be carried on. Thus, there was established a mutual understanding between the doctors of the state and the health department. This understanding of the work and the problems facing both the medical profession and the state health department has resulted in exceptional progress toward the common goal of providing a medical service for the people.

The cooperation of the medical society in the activities of the state health department during the period which Dr. Riggin served as State Health Commissioner can be illustrated by the expansion of the former programs as well as by the inauguration of a number of new services. Local health departments have increased from sixteen to a coverage of fifty-one counties at the present time. Tuberculosis control work was expanded. Three additional infirmary buildings for treatment of tuberculosis were constructed and pneumothorax stations were established throughout the state. A rheumatic fever study among children was undertaken and a program of control and treatment for children suffering with this condition was instituted. State-wide maternal and child health clinics and venereal disease clinics were established with the physicians acting as clinicians at these centers. Reference should also be made to a plan that was devised with the local welfare committee for the hospitalization of mothers needing hospital care and unable to pay for it. (See *The Virginia Medical Monthly*, 72:181, April 1945.) So far as we know such a service had not been given in any other state.

A bureau of industrial hygiene was set up which along with its other activities carries on a program of mass-x-raying of the industrial population. Many studies have been undertaken by the medical profession in conjunction with the health department.

Dr. Riggin has taken an active part in the work of the Medical Society, serving as a member of a number of standing and special committees. In reflecting upon the contribution Dr. Riggin has made in his various committee capacities, it is hoped that Virginia may be so fortunate as to find him continuing these.

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Dr. L. J. Roper of Portsmouth and Richmond, who has been with the State Health Department since 1936, and who, from July 1, 1919, was City Health Officer of Portsmouth, was appointed State Health Commissioner August 7th. We bespeak the hearty cooperation with the new administration.

The San Francisco Meeting

THE meeting of the American Medical Association was a tremendous success. According to the newspapers it brought fifteen thousand people to San Francisco. Our first impression, on looking over the exhibits, was that we knew little about modern medicine. Bewildering charts and strange-looking machines were seen on every hand. We were intrigued by a pulsating perfusion apparatus. We could not learn how it worked, much less what it did, besides sending a drop of colored fluid up and down through a lot of tubing. Technicians were performing a lot of *simple* tests everywhere. There were two Rh determination stations and both had queues of waiting women, although the test took only six minutes. The Navy showed, among other things, an apparatus that took miniature lung films of every patient on admission to the hospital, which they claimed would disclose many unsuspected heart and lung conditions. We were reminded of a conversation we had with a doctor on a sightseeing bus in Los Angeles. His son was captured in the Battle of the Bulge. He was especially badly treated by the Nazis as he made a nearly-successful escape. When he came home he was a mere shadow of his former self and was suffering severe pains particularly in his abdomen. He was sent from Army Hospital to Army Hospital and finally an operation for appendicitis was done. It looked as if he must surely die, when the doctor took him out of Army care and sent him to the Mayo Clinic, which was near his home. Here an X-ray, which was the first that had been taken, revealed acute tuberculosis. He was treated with streptomycin as a last resort experiment, and made a miraculous and rapid recovery.

Considerable space was given over to physical therapy and rehabilitation technics. A comely model, who evidently needed no rehabilitation, was having her various muscles tested electronically. The technical exhibits were equally impressive, although less confusing, and the art exhibit was the best they had ever had, although we did not have time to get around to that. There was simply too much to see and learn in five days.

The section on the Practice of Medicine, which is a new section of the A. M. A., was in an out of the way place and in a hall where "No Smoking" was strictly enforced. Never-the-less, it was well attended. Our neighbor, Wingate Johnson, presided with great dignity and efficiency, maintaining proper decorum. He allowed all relevant discussion and at the same time got through with the program on schedule. It looks as though the general practitioner has won for himself a permanent place in the A. M. A.'s scientific assembly.

As to the other part of the scientific program, Milton Silverman, Science Editor of the *San Francisco Chronicle,* gave the following summary:

At the end of their five-day meeting and of special meetings which preceded the AMA, here are the outstanding conclusions:

CANCER—No simple cure has yet been found. Surgery, X-ray and radium remain unsurpassed for the deep-seated, deadly cancers. For the treatment of less deadly skin cancers, radioactive phosphorus may be as good as the older curative agents—but, so far as is known now, no better.

TUBERCULOSIS—For the treatment of pulmonary tuberculosis the value of streptomycin—so-called "wonder drug"—has not been established.

HEART DISEASE—No heart disease victim may expect to live longer or more comfortably with

the aid of any new drug reported here last week. Tobacco as a major cause of heart disease was "proved" in one report, "disproved" in another, remains an open question.

SYPHILIS—Penicillin offers hope for an easier, quicker cure, but it is not the absolute magic bullet against this disease. Other drugs—notably arsenic and bismuth compounds—still must be used. A new diagnostic method—the "cardiolipin" test—appears to be the most accurate ever devised for syphilis.

MALARIA—Quinine, long-known to be valuable, but not perfect, appears to be surpassed by atabrine and newly discovered chloroquine and SN-13276.

POLIOMYELITIS—No cure has been found for infantile paralysis. The "Sister Kenny method" has still not been overwhelmingly accepted.

STOMACH ULCERS—No sure cure, no sure preventive, no certain cause.

CHILDBIRTH PAIN—The relatively new caudal anesthesia—injection of the anesthetic agent at the base of the spine—is good, but not as good as some of its adherents once claimed.

SKIN INFECTIONS—For wound and skin infections, new furacin may be even better than penicillin and the sulpha drugs. Also, it may not. Its nomination to the exclusive club of "miracle drugs" waits on thousands of additional patients.

MENTAL DISEASE—For petit mal—the minor form of epilepsy—treatment with tridione has unquestionably been helpful. For other mental diseases, assessment of most new treatments awaits more evidence than a doctor's report of "my series of two cases."

To medical scientists, it had been disappointing.

Out of several hundred reports, few were new, few were significant, few were brilliant. The enthusiastically heralded war-time discoveries—with a few important exceptions—failed to appear.

By and large, it seemed, the men who since Pearl Harbor had been reputedly too busy to report their discoveries had actually been too busy to make any.

SOCIETIES

Augusta County Medical Society.

At the August meeting of this Society, Dr. G. Edmund Stone, Staunton, was elected as president, succeeding Dr. John H. Guss. Other officers are: vice-presidents, Drs. William Lueders, Staunton, Paul A. Woods, Waynesboro, and Charles F. Gaylord, Staunton; secretary, Dr. B. H. Payne, Staunton; treasurer, Dr. John Womack, Staunton; and censor, Dr. Lyle S. Booker, Waynesboro.

Bedford County Medical Society.

At the May meeting of this Society, Dr. Bernard H. Kyle, Lynchburg, gave a very interesting paper on "Injuries to the Intervertebral Disc and Low Back Pain."

Dr. J. G. Jantz is president and Dr. W. G. Hardy, secretary-treasurer. Both are of Bedford.

The Buchanan-Dickenson Medical Society

Met on July 24th at which time it celebrated "Ladies Night". Dr. Frank Philip Coleman, Richmond, read a paper on "Cancer of the Lung." He detailed a series of 17 total pneumonectomies for cancer of the lung, in which nine of the patients are alive and well without recurrence to date. In the afternoon Dr. Coleman gave a surgical clinic at the Grundy Hospital for doctors of Dickenson, Tazewell and Buchanan counties.

Dr. C. H. Reagan, Grundy, is president of this Society, and Dr. T. C. Sutherland, Haysi, secretary.

Fredericksburg Medical Society.

Officers of this Society are: President, Dr. Claude A. Nunnally; vice-president, Dr. W. W. Butzner; and secretary-treasurer, Dr. L. A. Busch. All are of Fredericksburg.

Norfolk County Medical Society.

At the annual meeting of this Society held in June, Dr. Bryant E. Harrell succeeded Dr. Foy Vann to the presidency, and the following officers were elected: president-elect, Dr. Millard B. Savage; vice-president, Dr. George A. Duncan; and secretary-treasurer, Dr. Lockburn B. Scott, re-elected for the twenty-seventh consecutive year. Delegates to the annual convention of the State Society were also named.

Northampton County Medical Society.

Dr. Charles T. Garcia, Cape Charles, has been elected secretary of this Society for the balance of 1946. Dr. J. R. Hamilton, Nassawadox, is president.

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NEWS

Guests at the Virginia Beach Meeting.

All indications point to a most excellent meeting of the Medical Society of Virginia at Virginia Beach on October 14, 15 and 16, under the presidency of Dr. Julian L. Rawls of Norfolk. Matters of importance will be discussed in the business sessions as well as through the many scientific papers to be presented.

Guests at the meeting are to be Dr. George F. Lull, Secretary and General Manager of the American Medical Association, and Dr. Joseph S. Lawrence, Director of the Washington Office of the Council on Medical Service and Public Relations of the Association. Dr. Lawrence will speak on Monday evening and Dr. Lull on Tuesday evening following the banquet.

The Medical College of Virginia has arranged for a dinner gathering on Monday evening and groups of doctors in the Speciality Societies will have lunch together on Tuesday.

A number of exhibits will add to the interest of the meeting, as well as the many attractions offered by the Cavalier and Virginia Beach. It is hoped that many members who cannot stay for the whole time of the meeting may come to the Beach for one or more sessions. This will be a wonderful opportunity to meet with friends, many of whom have been in Service for several years.

Personnel Changes in State Health Department.

Dr. I. C. Riggin, State Health Commissioner since 1934, resigned as of August 7th.

Dr. L. J. Roper, State Director of Rural Health Services, was appointed State Health Commissioner, as of August 7th, by Governor Tuck.

Drs. P. M. Chichester and J. C. Neale, Jr., will alternate in directing the work of the Department of Rural Health which was headed by Dr. Roper.

Released from Service.

Dr. E. E. Barksdale, formerly of Danville, is now located in Washington, following his release from the Navy.

Dr. William D. Chase, formerly of Fairfax, is now associated with the Veterans Hospital in Reno, Nevada, since his discharge from the Army.

Dr. Hal S. Johnson is associated with Dr. J. R. Grinels, Richmond, in general practice. Before entering the Army he was located at Patterson.

Dr. William T. Pugh, Lynchburg, has returned to his practice and has offices in the Allied Arts Building.

Dr. A. C. Ray, Jr., has been released from Service and is back in Ashland.

Dr. George Zur Williams has been separated from the Navy and is back at the Medical College of Virginia, Richmond.

Dr. William R. Bishop, Front Royal.

Dr. Ben L. Boynton, Norfolk.

Dr. Jean B. Des Rochers, Roanoke (now San Antonio, Texas).

Dr. Henkel M. Price, Martinsville.

Dr. William W. Taylor, Norfolk.

Dr. Glenn L. Walker, Roanoke.

Post Graduate Course In Ophthalmology and Otolaryngology.

The next post graduate course will be held at the University of Virginia on December 9th and 10th for ophthalmology and 11th and 12th for otolaryngology. Several men of national prominence have already been secured.

Dr. James N. Dudley,

Former health commissioner of Newport News, resigned effective September 1st to accept a similar position with the City of Roanoke. He was with the State Health Department for ten years before going to Newport News in 1945.

Dr. Leta J. White

Has returned to her practice in Petersburg after an absence of three months. She visited her brother and sister in Bahia, Brazil, and while in South America visited Rio de Janeiro, Recife and points in the interior.

Dr. R. L. Raiford,

Franklin, attended the conference on Rural Medical Care sponsored by the Farm Foundation held at Chattanooga, June 25-28. He spoke on Group Medicine in a Rural Community.

University Hospital Opens New Floor.

The University of Virginia Hospital announces that it has recently opened another new floor, des-

ignated to the use of the Departments of Opthalmology and Otolarynology. These new wards have a total of thirty-six beds for white patients. They are in addition to the beds already available for pediatric and colored patients.

Dean Gray Resigns.

Dr. J. P. Gray, Dean of Medicine of the Medical College of Virginia, has resigned, effective September 16, to accept the position of dean of the school of medicine, director of the hospitals, and professor of public health medicine in the University of Oklahoma, School of Medicine, Oklahoma City. He has been with the Medical College of Virginia since July 1942.

Married.

Dr. L. Freeland Magruder, Portsmouth, and Miss Hattie Cridlin Taylor, Urbanna, July 29th.

Dr. Stuart Harrison Catron, Jr., Marion, and Miss Frazier Drumwright, Union Level, July 18th. He is a graduate of the Medical College of Virginia in March 1943, recently returned from overseas, and in now attached to the staff of McGuire General Hospital, Richmond.

The Southwestern Virginia Medical Society

Is to hold its Fall meeting at the Governor Tyler Hotel in Radford on October 3rd, the program starting at 2:00 p. m. The afternoon session will be given over to papers by members of the Society and, in the evening, the Society will have two guest speakers—Dr. Edward H. Dennen of New York City who will speak on The Use of Obstetrical Forceps, and Dr. James S. Speed of Memphis, Tenn., whose subject will be Orthopedic Problems.

Dr. A. P. Jones of Roanoke is president of this Society and Dr. A. F. Giesen of Radford, secretary-treasurer.

Dr. Charles F. Kincheloe,

Formerly of Falls Church, who has been taking "refresher" work in New York since being separated from the Service last January, has located in Alexandria with offices at 209 South Patrick Street, with also a Washington office, for orthopedic surgery exclusively. Before entering the Service, Dr. Kincheloe was engaged in special work in orthopedics in Pennsylvania and New York for three years.

Radio Series to be Sponsored by National Mental Health Foundation.

The National Mental Health Foundation is preparing to launch a series of professionally produced radio plays designed specifically to educate the American public to a sound and sympathetic approach towards mental illness and related problems.

Beginning in September of this year and continuing monthly thereafter, the Foundation plans to release two open-end fifteen minute transcribed radio dramatizations—each dealing with a particular problem arising out of mental illness.

The first two in this series have already been transcribed at the studios of the National Broadcasting Company. They are:

THE STORY OF LOUISE MAPLETON—a dramatized case history which demonstrates what can be accomplished in an efficiently run, well-equipped state hospital for a person in an early stage of mental illness.

THE CASE OF CYNTHIA EDWARDS—another dramatized case history. This program demonstrates the therapeutic possibilities of foster home care for a mental patient during her convalescent period.

The third program in the series covers the almost tragic experiences of a fully recovered mental patient when he meets up with the many prevailing prejudices on mental illnesses in his own home town. The fourth is to deal with the relationship between patient and attendant and will dramatize the value of the properly trained and sympathetic attendant to the patients in his care. All of the programs will be on open-end transcriptions, so that sponsoring agencies will have an opportunity to make a locally pertinent message at the close of each program.

As it is planned to make these programs available for use at meetings, the programs will be reproduced on discs which can be played on any regular record player. Organizations and societies wishing further information about this series are requested to write to the Radio Section, The National Mental Health Foundation, Box 7574, Philadelphia 1, Pennsylvania.

International College at Detroit.

Detroit is host city to an outstanding group of surgeons and doctors at the Eleventh Annual As-

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sembly of the United States Chapter, International College of Surgeons, at the Masonic Temple on October 21-22-23.

Featured at the impressive convocation on Tuesday evening, October 22 will be Joseph C. Grew, former Ambassador to Japan.

Sixty scientific speakers will present papers at the twenty four meetings scheduled.

If you plan to attend, write to Louis J. Gariepy, M.D., 16401 Grand River Avenue, Detroit 27, Michigan for a program and detailed information.

Dr. Julian B. Doss,

Roanoke, has discontinued private practice and accepted an appointment to the Staff of the Veterans Hospital in that city.

Dr. George H. Kinser,

Formerly of Waynesboro, is now at 1901 Sholars Street, Orange, Texas. He was transferred by DuPont Company as medical supervisor during the construction of a new nylon plant.

Portrait of Dr. Smith Presented Hospital.

An oil portrait of the late Dr. W. O. Smith was recently presented to the Piedmont General Hospital, Altavista. Dr. Smith practiced in Pittsylvania County and Altavista for more than forty years, having died in 1940.

The Piedmont Hospital was formally opened May 5, 1946. It has twenty-four beds and five bassinets and is under the direction of Dr. J. Paul Kent.

Dr. Lockburn B. Scott,

Norfolk, is spending the summer at his old home in Canada with members of his family still resident there.

Dr. Regena Beck's Laboratory,

1103 West Franklin Street, Richmond, has recently been approved by the State Department of Health for the performance of the Laughlen Flocculation Test and the Kolmer Complement Fixation Test for premarital examinations. This Laboratory will be added to the next list to be published by the Health Department.

New Quarterly Journal.

The publication of a new journal, the Quarterly Review of Dermatology and Syphilology, has just been announced by the Washington Institute of Medicine, Washington, D. C., as a notable event marking its fifteenth year in the fields of medical publication and library research.

This new publication is the tenth in the Washington Institute's group of Quarterly Reviews covering specialized fields of practice. It will survey all published material on Dermatology and Syphilology appearing anywhere in the world from January 1, 1946, onward, and will be the first review journal in its field ever to provide this truly complete coverage.

American Board of Obstetrics and Gynecology, Inc.

The next written examination (Part I) for all candidates will be held in various cities of the United States and Canada on February 7, 1947 at 2:00 P. M. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held later in the year. All applications must be in the office of the Secretary by November 1, 1946. Candidates in military service are requested to keep the Secretary's Office closely informed of changes in address.

Applications are now being received for the 1947 examinations. Final examinations will be held in Pittsburgh, Pa., June 1-7, 1947. For further information and application blanks address: Paul Titus, M.D., Secretary, 1015 Highland Building, Pittsburgh, 6, Pennsylvania.

Dr. O. Douglas Boyce,

Recently of Rural Retreat, is now located for practice in Gastonia, North Carolina.

Dr. R. Bruce Mallett,

Recently of Orange, is now located at 4644 31st Street, South, Arlington.

Fall Graduate Instructional Course in Allergy.

The American College of Allergists presents a Fall Graduate Instructional Course in Allergy under the auspices of the Jefferson Medical College of Philadelphia, November 4-9, inclusive. Headquarters will be at the Benjamin Franklin Hotel in that city. This course in allergy will consist of forty-six lectures and an afternoon laboratory session. These lectures will include fundamentals of allergy and allergy therapy.

Therapy in general will be discussed, the treat-

ment of special allergies, such as bacterial allergies, mold allergies, allergy to drugs and biological products, respiratory allergy including treatment with bronchoscopy and inhalation therapy, the treatment of medical emergencies in allergy, various skin manifestations of allergy, and allergy dealing with foods, migraine, Meniere's disease, ocular allergy, as well as uncommon manifestations of allergy.

Of the forty-six presentations the faculty consists of men representing seventeen different medical colleges, four clinics, as well as research workers, botanists, and other outstanding physicians in the field of allergy.

The fee for the course is $100. For those in or just returning from military service the tuition is reduced to $25. A limited number of scholarships are available to residents and internes interested in allergy or on an allergy service. Application for such scholarships should be made to the Office of the Secretary, 423 La Salle Medical Building, Minneapolis 2, Minnesota, and they will then be referred to the Committee for that purpose.

Dr. Walter Lewis Williams

And his brother, both of Brookneal, were recently honored by being presented with 50-year veteran membership jewels by the Staunton River Lodge number 155, A. F. & A. M.

Virginia Study of Child Health Services.

Since the progress report of last month, the Virginia Study of Child Health Services, sponsored by the American Academy of Pediatrics, has been moving rapidly toward completion.

Every physician and dentist in Virginia has received a questionnaire. The percentage of returns from these has already passed the 50 per cent mark.

Both phases of the Hospital Survey have made considerable progress in the past month. In the first phase, 94 per cent of the General and Maternity Hospitals have been surveyed by the Virginia Field Staff. In the second phase, conducted by the individual pediatricians, the following results have been obtained:

	Percentage Surveyed
General Hospitals	52
Nervous and Mental Hospitals	100
Tuberculosis Hospitals	86
Convalescent and Nursing Homes	79

Complete reports have been received from 92 per cent of the counties that have organized health departments.

Thus the overall progress of the Survey in the past 30 days has been good. However, there are still a large number of physicians and dentists who have not contributed their part to this concerted effort. It is urged that all of those who have not already done so, complete and return their questionnaires.

Twenty-Fifth Anniversary of the Discovery of Insulin.

The twenty-fifth anniversary of the discovery of Insulin will be observed with a program in Convocation Hall, at the University of Toronto, on September 16. Many Internationally known figures in the field of medicine will be present to honor the occasion. This observation will be followed by the regular annual meeting of the American Diabetes Association.

On September 23 Eli Lilly and Company will sponsor an International diabetes clinic to be held at the Indiana University Medical Center in Herty Hall of the State Board of Health Building, Indianapolis, Indiana. International importance will be given to this meeting by the presence of Professor Charles H. Best, Toronto, Canada, co-discoverer with Banting of Insulin, Professor Houssay, Dr. Lawrence, and Dr. Hagedorn. They will discuss various phases of diabetic care.

The Association of Military Surgeons.

Reservations already received for the convention of the Association of Military Surgeons of the United States to be held in Detroit on October 9th to October 11th inclusive, indicate that attendance this year will be unusually heavy. Therefore, all members planning to take part in the convention are urged to send in their reservations immediately so as to be sure of obtaining proper hotel accomodations. Dr. Carleton Fox, general convention chairman, announces that Lt. General Walton H. Walker, Commanding General of the fifth army, has accepted an invitation to serve as honorary chairman. Other members of the honorary committee are General Bliss, U. S. Army; Captain Cole, U. S. Navy; Dr. Williams, U. S. Public Health Service; and General Hawley, Veterans Administration, who will serve as vice chairman.

XUM

Dr. Joseph Krimsky,

Of Richmond and Charlottesville, has accepted an appointment with the Veterans Administration as chief of the eye, ear, nose and throat service in the Regional office at Huntington, W. Va.

Dr. Francis A. Hellebrandt,

Professor of Physical Medicine at the Medical College of Virginia, will have an exhibit, "Education in Physical Medicine", at the seventh annual Congress on Industrial Health, in Boston, September 30 through October 3.

New Superintendent at Eastern State Hospital.

Dr. Granville L. Jones of Marlboro, New Jersey, has been appointed superintendent of Eastern State Hospital at Williamsburg and will assume his duties there on or before September 15. He succeeds Dr. Joseph E. Barrett who, since the death of Dr. H. C. Henry, has served in the dual capacity of State Commissioner of Mental Hygiene and Hospitals and superintendent of that hospital.

Dr. Jones is a graduate in medicine of the University of Arkansas in the class of '28, and during the past fifteen years has been connected with the New Jersey State Hospital at Marlboro, first in mental hygiene work and later as clinical director.

The Cancer Committee

Of the Medical Society of Virginia wishes to call attention to a change in the method of procuring financial assistance for medically indigent cancer suspects and proven cancer patients from the Virginia Cancer Foundation.

Expenses for diagnosis and treatment may be paid by the Virginia Cancer Foundation at clinics certificated by the Cancer Committee for all patients whose medical indigence is certified by your local Welfare Department. The Welfare Department will make arrangements for patients to visit these clinics. In case of emergency, the patients will be accepted tentatively by the clinics until the Welfare Department has had an opportunity to make its investigation.

Dr. D. V. Kechele,

Recently of Richmond, is now with the X-Ray Department of St. Luke's Hospital, Bluefield, West Virginia.

Dr. Lewis K. Woodward, Jr.,

Announces the opening of an office for the practice of general surgery at the Cora Miller Memorial Hospital, Woodstock.

Dr. Dewey L. Anderson,

Recently located in Richmond, is now Medical Director of the Cooley Sanatorium at Monroe, Louisiana.

Dr. Eric C. Schelin,

Who was on the staff of the Medical College of Virginia hospitals from 1939 to 1942, announces his separation from the Army of the United States and the opening of his office in association with Dr. H. Hudnall Ware, Jr., and Dr. Washington C. Winn, at 816 West Franklin Street, Richmond. His practice will be limited to gynecology and obstetrics.

An Appointment in Pediatrics

Is available immediately at Raiford Clinic, Franklin, Virginia. Address the Administrator, Raiford Memorial Hospital, Franklin, for further details. (*Adv.*)

Wanted.

An Associate in surgery and general practice in a new twenty-seven bed hospital. Also to do some outside general practice. Apply to J. Paul Kent, M. D., Altavista, Virginia. (*Adv.*)

Established Hospital For Lease or Sale.

A Sanitarium for nervous, mental, alcoholic and drug cases doing an excellent business. Established in 1904. It is necessary to see the institution to appreciate its real value. Write Dr. E. W. Stokes, 923 Cherokee Rd., Louisville 4, Kentucky, for further information. (*Adv.*)

For Sale.

GE X-Ray, Model 1775; 30 ma; 85 KVP, table with Bucky; in excellent working condition. James P. King, M.D., Radford, Virginia. (*Adv.*)

An Appointment in E. E. N. and T.

Available October 1, 1946, at Raiford Clinic, Franklin, Virginia. Address the Administrator, Raiford Memorial Hospital, Franklin, for details. (*Adv.*)

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OBITUARIES

Dr. James Harmanson Mapp,

Buena Vista, died July 31, at the age of eighty, of a heart attack. He was graduated from the former College of Physicians and Surgeons, Baltimore, in 1888. Locating in Buena Vista in 1890, he was one of its pioneer citizens. He was one of the organizers of the Peoples Bank in 1906, and became its president six months later, a position he held until his death. He was a charter member of the Rotary Club, and one of the first masters of the Masons. He was for many years chairman of the Board of Health, and a member of the Medical Society of Virginia since beginning his practice. He is survived by his wife and two daughters.

Dr. John Daniel Thomas,

Washington, D. C., died on August 7th at the age of eighty. He was a native of Northampton County, Virginia, and graduated in medicine from the University of Virginia in 1892. He had been a member of the Medical Society of Virginia since 1909. He was formerly professor of Physical Diagnosis at Georgetown University. Since retirement several years ago, he had lived in Washington and with a son in Hilton Village, this State.

Dr. James Edwin Smith,

Petersburg, died August 15th. He was a native of Princess Anne County and seventy-three years of age. Dr. Smith graduated from the former University College of Medicine, Richmond, in 1900. He had practiced in Petersburg since that time and for the past five years had been on the staff of the Central State Hospital. Dr. Smith had been a member of the Medical Society of Virginia for forty-five years. A son and two daughters survive him.

The Petersburg Medical Faculty assembled in special meeting to pay tribute to the memory of its deceased member, Dr. James E. Smith, adopted the following:

We are gathered to pay tribute to the memory of our deceased friend and co-worker, Dr. James E. Smith, and record a simple testimonial to his personal and professional worth. Courteous, obliging and honorable, possessing generous impulses and a personality that inspired and retained true friendships; by nature genial and energetic, Dr. Smith was ever willing and ready to serve his fellowman. Public-spirited and progressive, a Christian in faith and works, he was a beloved and useful citizen. His broad, sympathetic, intense interest in anything that concerned human welfare and happiness and his untiring labors in behalf of the sick and afflicted, endeared him to the people throughout this community. Endowed with fine qualities of heart and head, he easily won our esteem and respect and impressed upon us the high order of his mentality. Truly, his enobling traits of character, his ideals, his good deeds and his zeal and skill as a physician deeply impressed and influenced us who were thrown with him frequently. Indeed in his death our profession loses one of its most esteemed and gifted members. Dr. Smith died at the end of a long useful and eminently successful career and will be greatly missed by a large and loyal clientele as well as his fellow physicians.

J. BOLLING JONES
D. D. WILLCOX
E. L. MCGILL

Resolutions on Dr. Rucker.

Dr. Moses Peter Rucker died in Bedford on April 4, 1946, from pneumonia, at the age of sixty-nine years. He had been in poor health for sometime, but he continued at work until a short while before his death.

Dr. Rucker graduated from the University of Maryland School of Medicine in 1904 and had been engaged in general practice in Bedford since his graduation.

He was a past president of the Bedford County Medical Society, a surgeon for the Norfolk and Western Railroad, and had been a member of the Medical Society of Virginia for thirty-one years.

The Bedford County Medical Society at its meeting on June 21, 1946, adopted the following resolutions:

BE IT RESOLVED that in the death of Dr. Rucker this society and community have lost a most skillful and successful doctor and friend, who administered to all who sought his aid, regardless of color or ability to pay.

IT IS FURTHER RESOLVED that a copy of these resolutions be published in the VIRGINIA MEDICAL MONTHLY, and that a copy be sent to his family, and also spread on the minutes of this Society.

E. L. JOHNSON
W. V. RUCKER
W. G. HARDY